Benefit Decision Guide
for New Hires, Employees and Retirees

A comprehensive tool to help you research your options and make an informed decision for you and your family.

Effective:

July 1, 2013 - June 30, 2014

Medical Insurance

Dental Insurance

Vision Insurance

Retiree Plans

Life Insurance

Employee Assistance

Department of
Human Resources

274 Front Street
Chicopee, MA 01013

THE CITY OF CHICOPEE
DEPARTMENT OF HUMAN RESOURCES

SCOTT SZCZEBAK, ESQ.
DIRECTOR

Spring 2013

Dear Colleagues:

Deciding on a health insurance plan is one of the most important decisions affecting our lives today, impacting our finances, health and the well-being of our families. Over the last several years, we have witnessed unprecedented changes in how health insurance is administered on a national, state and local level.

The City of Chicopee has always strived to provide the very best coverage to our employees at an affordable rate. In order to keep up with the changes in the health insurance laws while balancing the budget in the worse economic environment in over 75 years, we have asked our employees and retirees to make sacrifices. Today, we have been able to balance the budget and preserve services without lay-offs in the School, Police, Fire and Public Works Departments.

By introducing new programs to keep our members healthy, we have been able to keep insurance rates low and competitive. This year we will be introducing new and exciting programs that will help keep you and your family healthy, and ultimately our insurance rates affordable for years to come. Together, we will find creative solutions to keep the cost of health care low and the quality high.

This year we introduced additional Flexible Spending Accounts (FSA) to all of our employees that will help them save money and plan accordingly for any health care costs. If you didn't get a chance to sign up, we will be having another open enrollment period for the FSA's this coming December. Everyone should consider using a FSA as a way to save money.

The ***2013 - 2014 Benefit Decision Guide*** was produced so you can make an informed decision about what insurance is best for you and your family. Please take the time to carefully review your options. I encourage all employees and retirees to become informed health care consumers.

As always, if you have any questions, please contact Human Resources at (413) 594-1510, or go to www.ChicopeeMA.gov for more information.

Sincerely,

Scott Szczebak
Director

CITY HALL • 274 FRONT STREET, 4TH FLOOR • CHICOPEE, MA 01013
PHONE (413) 594-1510 FAX (413) 594-1513
SSZCZEBAK@CHICOPEEMA.GOV

Contact Information

Most questions related to benefits can be answered by the Human Resources office, located at 274 Front Street, Chicopee, on the fourth floor of City Hall. Human Resources can be reached at (413) 594-1510, Monday through Friday between the hours of 8:00 a.m. and 5:00 p.m.

Joanne Spence, Benefits Manager, can be reached at (413) 594-1518 or by email at jspence@chicopeema.gov. Additional information regarding Human Resources related documents, forms and publications can be found on the City's website at www.chicopeema.gov. Go to the City Departments link and click on Human Resources.

For information regarding COBRA, life insurance or payroll related deductions for insurance, contact Roxann Labonte in the Treasurer's Office. She can be reached at (413) 594-1565 or by email at rlabonte@chicopeema.gov.

Blue Cross can be contacted by calling Member Services at 1-800-262-BLUE (2583) or by visiting their website at www.bluecrossma.com.

Health New England (HNE) can be contacted by calling Member Services as 1-413-787-4004 or by visiting their website at www.hne.com.

All health insurance related questions for new hires, active employees and Retirees should be directed to Human Resources. Any questions related to retirement that are non-health insurance related, please contact the Retirement Board at (413) 594-1540.

Department of Human Resources
Chicopee City Hall 4th Floor
274 Front Street
Chicopee, MA 01013

Joanne Spence, Benefits Manager:
(413) 594-1518
jspence@chicopeema.gov

Health New England: (413) 787-4004
www.hne.com

Blue Cross Blue Shield: 1-800-262-2583
www.bcbsma.com

IMPORTANT: This guide is meant for estimation purposes only. For the complete and accurate details of premiums, co-pays, deductible and benefits, please contact Human Resources, Blue Cross Blue Shield or Health New England Directly. In no event shall the City of Chicopee, its agents or employees be held liable for any damages stemming from the use of this guide.

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IF YOU ARE A NEW HIRE

All employees who work 20 hours per week or more are considered full time and are entitled to the City of Chicopee's benefits package. Seasonal employees who work 16 weeks or more on a regular, full time basis are also entitled to benefits.

New hire benefits include health insurance, dental insurance, life insurance and vision insurance.

If your hire date is from the first to the tenth of the month, you can enroll in benefits with an effective date for the following month. For example, if your hire date is March 3rd, your insurance will become effective April 1st. You have 30 days from your date of hire to enroll. If you choose not to take health insurance, you will have to wait until Open Enrollment.

If your hire date is from the eleventh of the month until the end of the month, you can enroll in health insurance with an effective date in two months. For example, your hire date is March 12th, your insurance will become effective May 1st.

Once you choose a health plan or dental plan, you cannot change plans until the next annual open enrollment period unless you have a "qualifying event" such as a divorce, birth, marriage, etc.

IF YOU ARE AN EMPLOYEE

Open Enrollment for health and dental insurance takes place every year in the Spring with an effective date of July 1. This gives you an opportunity to review your current benefits and make any changes. If you are pleased with your coverage, you do not need to do anything. If you would like to make a change, please review the options available.

AGE 26 DEPENDENT

A recent law enacted requires health plans that provide dependent coverage for children to extend coverage for adult children up to the age of 26. Under the law, coverage must be granted to dependents up to age 26 regardless of their tax filing status, marital status or financial dependency on the parent. The regulations contain no requirement that adult dependents under the age of 26 maintain student status and the law does not require adult dependents to be dependents as defined by the IRS.

MAKE AN INFORMED DECISION

Does your plan fit your medical and financial needs? Can you see a Specialist without a referral? Is your dentist part of the network? Will you be limited by the plan's list of in network providers? Don't underestimate the benefit of wellness. Does your plan offer coverage for annual checkups and well child visits? How about discounts on exercise programs, smoking cessation clinics and mental health services? Choose your plan wisely. Human Resources is here to help! Feel free to visit our website at www.chicopeema.gov or call us at (413) 594-1510.

OPEN ENROLLMENT

Please be sure to read all correspondence and information regarding Open Enrollment. Your plan or benefits may change, requiring you to take action.

How to Choose the Best Health Insurance Plan for You

Choosing the right health insurance for you and your family can be difficult. There are many options to consider: Does it cover your doctor and prescriptions? How much is it going to cost me? Do I need any special accommodations? Does the plan meet all of our needs?

All plans offered by the City of Chicopee meet the credible coverage standards set by the state of Massachusetts. You and your family will also be covered for an emergency situation regardless of where it occurs. Remember, no matter which plan you choose, you can change your plan coverage during the Open Enrollment period.

Please be sure to read any and all notices, posters and emails sent to you from the City of Chicopee. These notices contain important information regarding our health insurance plans and rates. Part of making an informed decision is having all of the information that is available and up-to-date. Don't disregard notices as they could have information changing the health insurance plans.

- You have six choices of plans to choose from. Blue Cross offers HMO Blue Options, HMO Blue 500 and HMO Blue 1000. Health New England offers Essential 500 HMO, HNE Wise Max HMO and HNE Essential 500 PPO.

- Start by reviewing the benefit summary for each plan. Weigh the features that are important to you and your family. What are the deductible and out of pocket expenses? What about prescription drug coverage? What are the monthly rates?

- Once you identify plans you are interested in, determine if your doctors and hospitals are in the plan's network. The best way to research the plans is by accessing the plan websites or by calling them directly.

- We have provided you with a condensed benefit overview for each plan. If you have specific questions or concerns, please call Blue Cross or Health New England directly.

- Blue Cross can be contacted by calling Member Services at 1-800-262-BLUE (2583) or by visiting their website at www.bluecrossma.com.

- Health New England (HNE) can be contacted by calling Member Services as 1-413-787-4004 or by visiting their website at www.hne.com.

- Some plans require prior approval or a referral from your Primary Care Physician for services. If you fail to ask for prior approval or a referral, the service may not be covered by insurance. In some cases, failure to ask for prior approval or a referral may result in a reduction of benefits. Be sure to check with the Member Services department of your plan.

Flexible Spending Accounts (FSA)

A Flexible Spending Account (FSA) is a benefit that enables you to pay for eligible medical expenses on a pre-tax basis. An FSA saves you money by reducing your income tax and all contributions you make to your flex spending account are deducted from your check before any of your taxes are calculated.

Enrollment in the FSA is voluntary and there are no administrative fees or additional costs to you. New employees can sign up within 30 days of being hired. All active employees with the City of Chicopee are eligible to enroll. Seasonal, emergency or temporary employees are not eligible.

Open enrollment for the Flexible Spending Account is generally in December, with an effective date of January of the following year. If you enroll in the FSA, you may make contributions in increments of $100 per year, $250 per year, $500 per year, $1,000 per year and $2,500 per year.

Once you enroll in the FSA, you cannot change or revoke the agreement during the plan year unless you have a qualifying event or change in family status to include but not limited to marriage, divorce, death of a spouse or child, birth or adoption of a child, termination or commencement of employment of a spouse or other events the City of Chicopee determines will permit a change or revocation. Changes must be submitted within thirty (30) days of the event.

Federal regulations require that you use the entire amount you allocate to your FSA during the plan year (January through December) or forfeit the unused balance. Therefore, before making your allocation, carefully consider what your eligible expenses might be.

The City of Chicopee offers two different FSA's, one for health care and medical expenses and another for dependent care. The health care and medical expenses plan allows you to be reimbursed for your out of pocket medical, dental, vision, and deductibles/co-pay expenses. The dependent care plan allows you, while working, to pay for child care expenses for children under the age of 13 or to pay for a physically or mentally disabled person who lives with you. The child/children or disabled person must be someone you can claim as a dependent on your tax returns.

You must spend all the money in your FSA by December 31st or it will be forfeited. However, there is a 60 day grace period every year for spending and reimbursement. If you do not spend that money during the plan year or during the grace period, you will forfeit it.

You may request reimbursement for health care expenses incurred by you, your spouse and/or any of your dependents that you can claim on your tax return. Any health care expense defined by the IRS as a non-deductible expense for income tax purposed shall be ineligible for reimbursement. Eligible expenses are subject to change by the IRS. A list of eligible expenses can be found at www.IRS.gov. Additional information regarding the FSA can be found at www.Chicopeema.gov.

Active Employee Rates Effective July 1, 2013: Health Insurance

Health New England Essential 500 (employee contribution)		
	Total Premium	**Bi-Weekly Cost**
Ind.	$426.95	$64.04
Fam.	$1,145.50	$229.01

Health New England WiseMax (employee contribution)		
	Total Premium	**Bi-Weekly Cost**
Ind.	$341.21	$51.18
Fam.	$915.15	$183.03

Health New England Essential 500 PPO (employee contribution)		
	Total Premium	**Bi-Weekly Cost**
Ind.	$634.08	$158.52
Fam.	$1,700.59	$425.15

Blue Cross Blue Shield Blue Options (employee contribution)		
	Total Premium	**Bi-Weekly Cost**
Ind.	$710.04	$106.51
Fam.	$1,845.78	$369.16

Blue Cross Blue Shield HMO 500 (employee contribution)		
	Total Premium	**Bi-Weekly Cost**
Ind.	$755.04	$113.26
Fam.	$1,962.24	$392.45

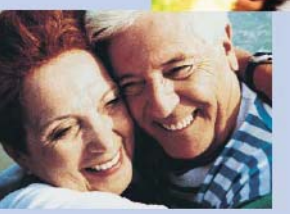
Blue Cross Blue Shield HMO 1000 (employee contribution)		
	Total Premium	**Bi-Weekly Cost**
Ind.	$718.52	$107.78
Fam.	$1,867.36	$373.47

Active Employee Rates Effective July 1, 2013: Dental and Vision Insurance

Blue Cross Blue Shield Dental Blue (employee contribution)		
	Total Premium	**Bi-Weekly Cost**
Ind.	$33.78	$8.45
Fam.	$95.98	$24.00

EyeMed Vision (100% employee contribution)	
	Total Monthly Premium
Ind.	$5.63
Ind. +1	$10.70
Family	$15.71

Dental Blue®
The right choice



Dental Blue Program 2

Summary of Benefits

City of Chicopee

MASSACHUSETTS

Dental Blue Program 2

Preventive Benefit Group	Basic Benefit Group	Major Benefit Group
No Deductible	**$50 Per Member/$150 Per Family Calendar-Year Deductible**	
Full Coverage	**80% Coverage**	**50% Coverage**

Diagnostic

- One complete initial oral exam, including initial dental history and charting of the teeth and supporting structures
- Full mouth X-rays, seven or more films, or panoramic X-ray with bitewing X-rays once each 60 months
- Bitewing X-rays once each six months and
- Single tooth X-rays as needed
- Study models and casts used in planning treatment once each 60 months
- Periodic or routine oral exams once each six months
- Emergency exams

Preventive

- Routine cleaning, scaling, and polishing of the teeth once each six months
- Fluoride treatment once each six months (members under age 19)
- Sealants on permanent pre-molar and molar surfaces (members under age 14). Benefits are provided for one application per pre-molar or molar surface each 48 months
- Space maintainers needed due to premature tooth loss (members under age 19)

Restorative

- Amalgam (silver) fillings (limited to one filling for each tooth surface in a 12-month period)
- Composite resin (tooth color) fillings on front teeth (limited to one filling for each tooth surface in a 12-month period). Benefits are provided for amalgam fillings towards the cost of composite resin (tooth color) fillings on back teeth (bicuspids and molars). You pay any balance.
- Pin retention for fillings
- Stainless steel crowns on baby teeth and on first permanent adult molars (members under age 16)

Oral Surgery

- Tooth extraction
- Root removal
- Biopsies

Periodontics (gum and bone)

- Periodontal scaling and root planing once per quadrant each 24 months
- Periodontal surgery once per quadrant each 36 months
- Periodontal maintenance following active periodontal therapy once each three months

Endodontics (roots and pulp)

- Root canal therapy (permanent teeth, once per lifetime per tooth)
- Retreatment root canal therapy on permanent teeth, once in a lifetime for each tooth
- Therapeutic pulpotomy on primary or permanent teeth (members under age 16)
- Other endodontic surgery to treat or remove the dental root

Prosthetic Maintenance

- Repair of partial or complete dentures, crowns, and bridges once each 12 months
- Adding teeth to an existing complete or partial denture
- Rebase or reline of dentures once each 36 months
- Recementing of crowns, inlays, onlays, and fixed bridgework once each 12 months

Other Services

- Occlusal adjustments once each 24 months
- Services to treat root sensitivity
- Emergency dental care to treat acute pain or to prevent permanent harm to a member
- General anesthesia when administered in conjunction with covered surgical services

Prosthodontics (teeth replacement)

- Complete or partial dentures (including services to fabricate, measure, fit, and adjust them) once each 60 months for each arch
- Fixed bridges (including services to fabricate, measure, fit, and adjust them) once each 60 months for each tooth
- Replacement of dentures and bridges once each 60 months when the existing appliance can't be made serviceable
- Adding teeth to an existing bridge
- Temporary partial dentures to replace any of the six upper or six lower front teeth (only covered if they are installed immediately following the loss of teeth and during the period of healing)

Major Restorative (members age 16 or older)

- Crowns, once each 60 months for each tooth
- Metallic, porcelain, and composite resin inlays. Benefits are provided for an amalgam filling toward the cost of a metallic, porcelain, or composite resin inlay, once each 60 months for each tooth. You pay any balance
- Metallic, porcelain, and composite resin onlays, once each 60 months for each tooth
- Replacement of crowns, once each 60 months for each tooth
- Replacement of metallic, porcelain, and composite resin inlays. Benefits are provided for an amalgam filling toward the cost of a metallic, porcelain, or composite resin inlay, once each 60 months for each tooth. You pay any balance
- Replacement of metallic, porcelain, and composite resin onlays, once each 60 months for each tooth
- Post and core or crown buildup, once each 60 months for each tooth

$1,000 Calendar-Year Benefit Maximum

New Benefits Effective 7/1/2007

- Composite resin fillings on a single-surface back tooth filling (bicuspids and molars) in a 12-month period. Benefits will continue to be provided for amalgam fillings toward the cost of multiple surface composite resin fillings. You pay any balance. Covered as a Restorative benefit.
- Single-tooth dental endosteal implants (the fixture and abutment portion) in addition to the allowance for the crown for the implant, once each 60 month period, when the implant replaces permanent teeth through the second molars. Covered as a Major Restorative benefit for members age 16 and older.
- Enhanced Dental Benefits for certain dental care services are available if you are a member who has been diagnosed with either diabetes, coronary artery disease, or you are a member who is pregnant. Contact Member Service for more information.

Welcome to Dental Blue, a comprehensive dental plan that provides a wide range of benefits to meet a variety of your dental care needs.

Your Dentist

Dental Blue offers an extensive network of dentists. There are nearly 5,000 dentists who participate with Blue Cross Blue Shield of Massachusetts. Dentists who participate with Blue Cross Blue Shield of Rhode Island and out-of-area dentists who participate in the DenteMax Network of Dentists are also available to Dental Blue members.

If you already have a dentist and you want to know if he or she is participating with Blue Cross Blue Shield of Massachusetts, you may call the dentist, refer to the most current dental provider directory, or call Member Service at the toll-free telephone number shown on your Dental Blue ID card.

If you would like help choosing a dentist, you may call the Physician Selection Service at **1-800-821-1388**. You may also access the online dental provider directory at **www.bluecrossma.com**.

Your Benefits

Benefits are subject to the deductible, co-insurance, and benefit maximum amounts chosen by your group. Please refer to the chart to the left for the amounts your group has chosen for you.

Many of the covered services have specific time limits or age limits associated with them. For example:

- Cleanings are provided only once each six months.
- Fluoride treatments are provided only for members under age 19.

Pre-Treatment Estimates

If your dentist expects that your dental treatment will involve covered services that will cost more than $250, he or she should send a copy of the "treatment plan" to Blue Cross Blue Shield before services are rendered. A treatment plan is a detailed description of the procedures that the dentist plans to perform and includes an estimate for the charges for each service.

Once the treatment plan is reviewed, you and your dentist will be notified of the benefits available for those services.

Remember, the payment estimate is based on your eligibility status and the amount of your calendar-year benefit maximum at the time the estimate is received and reviewed. (The actual payment may differ if your available calendar-year benefit maximum or eligibility status has changed.)

Multi-Stage Procedures

Your dental plan provides benefits for multi-stage procedures (these are procedures that require more than one visit, such as crowns, dentures, and root canals) as long as you are enrolled under the plan on the date that the multi-stage procedure is completed. A participating dentist will send a claim for a multi-stage procedure to Blue Cross Blue Shield for processing only after the completion date of the procedure.

You will be responsible for all charges for multi-stage procedures if your plan has been cancelled before the completion date of the procedure.

How Dentists Are Paid

Participating Dentists

Dentists that participate with Blue Cross Blue Shield of Massachusetts, Blue Cross Blue Shield of Rhode Island, or out-of-area dentists that are in the DenteMax Network of Dentists, accept the lesser of either the dentist's actual charge or the allowed charge as payment in full for covered services. You pay only your deductible, co-insurance, and charges beyond your calendar-year benefit maximum.

In Massachusetts, benefits are usually only provided when covered services are furnished by a participating dentist. The exceptions are described in your subscriber certificate.

Non-participating Dentists Outside of Massachusetts

Benefits for covered services by a non-participating dentist outside of Massachusetts are provided based on the dentist's actual charge or the allowed charge, whichever is less. The allowed charge is based on a schedule of charges. You may be responsible for any difference between the dentist's actual charge or the allowed charge, whichever is less. You are also responsible for your deductible, co-insurance, and charges beyond your calendar-year benefit maximum.

When Coverage Begins

You are covered, without a waiting period, from the date you enroll in the plan.

Dependent Benefits

This plan covers dependents to age 26, or for two calendar years after the dependent is no longer claimed on the subscriber's or spouse's federal tax return, whichever comes first. Additionally, this plan may cover unmarried full-time students or other unmarried dependents who do not otherwise qualify as eligible dependents. Please see your subscriber certificate (and riders, if any) for exact coverage details.

If You Have to File a Claim

Participating dentists will send claims to Blue Cross Blue Shield for you. Just show them your Dental Blue ID card. The payment will be sent directly to your dentist when claims are received within one year of the completed service.

If you receive emergency care in Massachusetts by a non-participating dentist because a participating dentist was not available, you or the dentist may file an Attending Dentist's Statement. If you file, send the Attending Dentist's Statement with the original itemized bills. Any benefit payment will be sent to you. You can get Attending Dentist's Statements from Member Service.

Any claims that you file should be sent to Blue Cross Blue Shield of Massachusetts, P. O. Box 986030, Boston, MA 02298. All member-submitted claims must be submitted within two years of the date of service.

The Blue Cross Blue Shield Grievance Program is fully described in the subscriber certificate.

Other Information

Coordination of benefits, or COB, applies to plan members who are covered by another plan for health care expenses. COB ensures that payments from all health care plans do not exceed the total charges billed for covered services.

Your subscriber certificate has a subrogation clause. This does not affect the scope of benefits. It allows claim payments to be retracted when a member recovers payment for the same charges from a third party due to liability for injury.

Questions? Call 1-800-932-8323.

For questions about Blue Cross Blue Shield of Massachusetts, visit the website at **www.bluecrossma.com.**

Limitations and Exclusions. **These pages summarize your dental plan. Your subscriber certificate and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the subscriber certificate and riders will govern. For a complete list of limitations and exclusions, refer to your subscriber certificate and riders.**

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MASSACHUSETTS

EyeMed
VISION CARE®

PROMOTING
VISION
WELLNESS

Vision Wellness for All

With EyeMed Vision Care, you'll get more than a standard vision benefit. EyeMed's vision program complements your entire health and wellness package by giving you affordable eye care with the convenience you deserve.

Eye Health Equals Better Health

Regular eye exams do more than just measure your eye sight. They can detect serious eye diseases early, allowing for more proactive treatment. What most people don't realize is that eye examinations can also reveal the early signs of serious illnesses like diabetes, heart disease and high blood pressure.

Savings All Year Long

EyeMed's program includes discounts on all your eyewear purchases, even after you've used your primary benefit. Whether buying additional pairs of glasses or just stocking up on supplies like cleaning cloths, you never have to pay full price for vision care needs.

Convenience That Counts

As an EyeMed member, you get the convenience your lifestyle demands. You can use your benefits at thousands of private practice and retail-affiliated providers across the country, most with evening or weekend appointments available. And with the nation's top optical retail brands included in EyeMed's network, you'll find high quality eye care where you live, work and shop. We back this up with a Customer Care Center available seven days a week to respond to your questions.

To learn more or to locate a provider near you visit www.eyemedvisioncare.com

LensCrafters · Pearle Vision · Sears Optical · Target Optical · JCPenney jcp.com · Private Practitioners

EyeMed VISION CARE®

CITY OF CHICOPEE

CITY OF CHICOPEE has selected EyeMed as your vision wellness program. This plan allows you to improve your health through a routine eye exam, while saving you money on your eye care purchases. The plan is available through thousands of provider locations participating on the EyeMed ADVANTAGE network.

To see a list of participating providers near you, go to www.enrollwitheyemed.com and choose ADVANTAGE from the provider locator dropdown box. You can also call 1-866-203-7437.

Enroll today to take advantage of an affordable way to help ensure a lifetime of healthy vision.

Vision Care Services	Member Cost	Out-of-Network Reimbursement
Frames:	$0 Copay, $140 Allowance; 20% off balance over $140	Up to $82
Standard Plastic Lenses:		
Single Vision	$10 Copay	Up to $42
Bifocal	$10 Copay	Up to $78
Trifocal	$10 Copay	Up to $130
Standard Progressive	$70	Up to $78
Premium Progressive	$70, 80% of Charge less $110 Allowance	Up to $78
Lens Options (paid by the member and added to the base price of the lens):		
Tint (Solid and Gradient)	$0	Up to $10
UV Coating	$12	N/A
Standard Scratch-Resistance	$0	Up to $10
Standard Polycarbonate	$35	N/A
Standard Polycarbonate for Children under 19	$0	Up to $26
Standard Anti-Reflective	$40	N/A
Polarized	20% off retail price	N/A
Other Add-Ons and Services	30% off retail price	N/A
Contact Lenses (allowance covers materials only):		
Conventional	$0 Copay, $155 Allowance; 15% off balance over $155	Up to $94
Disposables	$0 Copay, $155 Allowance; balance over $155	Up to $94
Medically Necessary	$0 Copay, Paid in Full	Up to $200
LASIK and PRK Vision Correction Procedures:	15% off retail price OR 5% off promotional pricing	N/A
Additional Pairs:	Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used.	N/A
Frequency:		
Frames	Once every 12 months	
Standard Plastic Lenses or Contact Lenses	Once every 12 months	

Additional Purchases and Out-of-Pocket Discount

Member will receive a 30% discount on remaining balance at Participating Providers beyond plan coverage; the discount does not apply to EyeMed's Providers' professional services or disposable contact lenses. Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used.
Benefits are not provided for services or materials arising from: Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; Medical and/or surgical treatment of the eye, eyes or supporting structures; Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; safety eyewear; Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; Plano (non-prescription) lenses and/or contact lenses; Non-prescription sunglasses; Two pair of glasses in lieu of bifocals; Services or materials provided by any other group benefit plan providing vision care; Certain brand name Vision Materials in which the manufacturer imposes a no-discount policy; or Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order. Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.
Benefits may not be combined with any discount, promotional offering, or other group benefit plans. Standard/Premium Progressive Lens not covered - fund as a Bifocal Lens. Standard Progressive Lens covered - fund Premium Progressive as a Standard.
Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri, except in New York. Fidelity Security Life Policy number VC-19/VC-20, form number M-9059. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer.

Value Added Features:

In addition to the health benefits your EyeMed program offers, members also enjoy additional value-added features including:

- **Eye Care Supplies** - Receive 30% off retail price for eye care supplies like cleaning cloths and solutions purchased at network providers (not valid on doctor's services or contact lenses).
- **Laser Vision Correction** - Save 15% off the retail price or 5% off the promotional price for LASIK or PRK procedures.
- **Replacement Contact Lens Purchases** - Visit www.eyemedcontacts.com to order replacement contact lenses for shipment to your home at less than retail price.

LENSCRAFTERS
PEARLE VISION
Sears Optical
TARGET OPTICAL
JCPenney jcp.com
PRIVATE PRACTITIONERS

Enrollment/Change Form

Please print and complete all sections.
See instructions below.

Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri

EMPLOYER INFORMATION: To be Completed by Employer

Group Number	Employer Name	Location Code	Division Code	Client Co Code	Effective Date
9749649	CITY OF CHICOPEE				

EMPLOYEE INFORMATION A: Add (enroll) T: Terminate C: Change (change of name, address or phone)

☐ADD ☐TERM ☐CHG	Sex ☐ M ☐ F	Member ID	Last Name (Employee or subscriber)	First Name	M.I.	Date of Birth

Social Security Number	Home Street Address	City/State/Zip	Home Phone ( )

FAMILY INFORMATION (Only those eligible may be enrolled.) A: Add (enroll) T: Terminate C: Change (change of name)

☐A ☐T ☐C	Sex ☐ M ☐ F	Last Name (spouse)	First Name	M.I.	Date of Birth	Social Security Number
☐A ☐T ☐C	Sex ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	Social Security Number
☐A ☐T ☐C	Sex ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	Social Security Number
☐A ☐T ☐C	Sex ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	Social Security Number
☐A ☐T ☐C	Sex ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	Social Security Number

Employee Signature: _____ Date: _____

Instructions:

Employer name: Legal name of the employer.
Group Number: Provided by EyeMed or EyeMed representative.
Location code: Optional field for employers to track multiple locations.
Effective date: Date set by employer in accordance with EyeMed proposal. Employer also sets effective date for new adds during contract period.

Family Information: List only eligible family members who are enrolling.
Dependent eligibility is the same as employer's health plan.
(A) Add: Open (group) enrollment or new (individual) enrollment during the contract period.
(T) Terminate: To terminate enrollment.
(C) Change: A change of name, employee address or employee phone.

Your Authorization:

I authorize vision plan payroll deduction for:

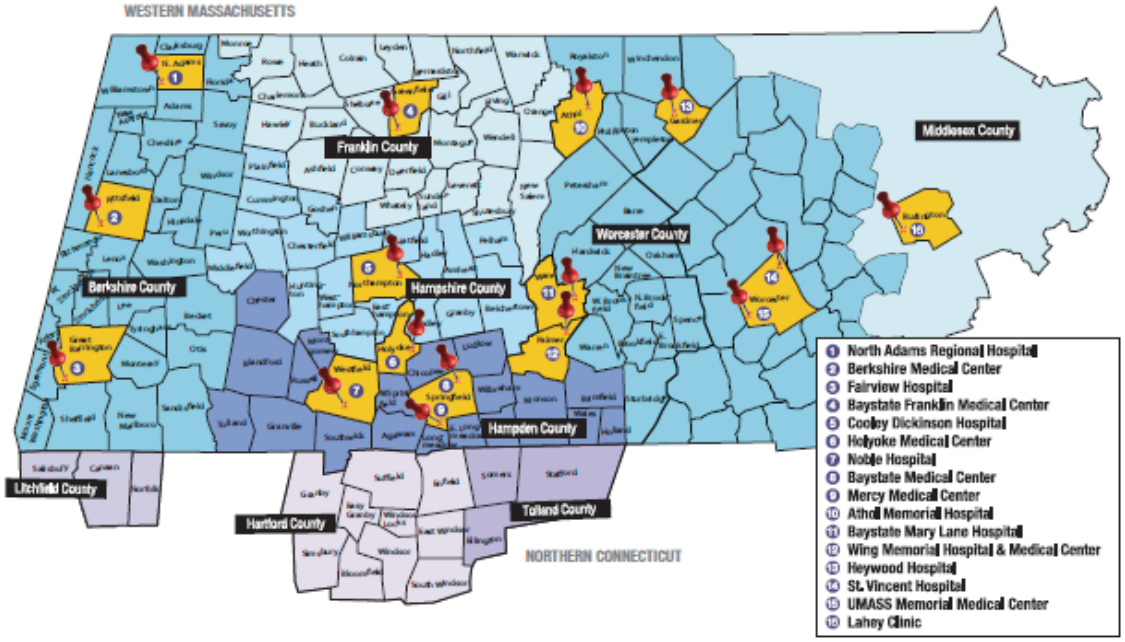
Per Employee only per month	$5.63
Per Employee + 1 per month	$10.70
Per Employee + family per month	$15.71

Once you elect EyeMed vision coverage, you cannot cancel for a 12-month period based upon your enrollment date.
Deductions are adjusted according to payroll frequency.

Coverage Maps

HNE SERVICE AREA* *(Includes additional cities and towns not shown on map.)*

As of 4/11



MASSACHUSETTS

Berkshire County

Adams
Alford
Ashley Falls
Becket
Berkshire
Cheshire
Clarksburg
Dalton
Drury
East Otis
Egremont
Florida
Glendale
Great Barrington
Hancock
Hinsdale
Housatonic
Lanesboro
Lee
Lenox
Lenox Dale
Mill River
Monterey
Mount Washington
New Ashford
New Marlborough
North Adams
North Egremont
Otis
Peru
Pittsfield
Richmond
Sandisfield
Savoy
Sheffield
Simmons Rock
South Egremont
South Lee
Southfield
Stockbridge
Tyringham
Washington
West Stockbridge
Williamstown
Windsor

Franklin County

Ashfield
Bernardston
Buckland
Charlemont
Colrain
Conway
Deerfield
Erving
Gill
Greenfield
Hawley
Heath
Lake Pleasant
Leverett
Leyden
Millers Falls
Monroe
Monroe Bridge
Montague
Mount Hermon
New Salem
Northfield
Orange
Rowe
Shattuckville
Shelburne
Shelburne Falls
Shutesbury
South Deerfield
Sunderland
Turners Falls
Warwick
Wendell
Wendell Depot
Whately

Hampden County

Agawam
Blandford
Bondsville
Brimfield
Chester
Chicopee
East Longmeadow
Feeding Hills
Granville
Hampden
Holland
Holyoke
Indian Orchard
Longmeadow
Ludlow
Monson
Montgomery
Palmer
Russell
Southwick
Springfield
Thorndike
Three Rivers
Tolland
Wales
West Springfield
Westfield
Wilbraham
Woronoco

Hampshire County

Amherst
Belchertown
Chesterfield
Cummington
Cushman
Easthampton
Florence
Goshen
Granby
Hadley
Hatfield
Haydenville
Huntington
Leeds
Middlefield
Mount Tom
North Amherst
North Hatfield
Northampton
Pelham
Plainfield
South Hadley
Southampton
Ware
West Chesterfield
West Hatfield
Westhampton
Williamsburg
Worthington

Middlesex County

Burlington

Worcester County

Athol
Barre
Brookfield
East Brookfield
Fiskdale
Gardner
Gilbertville
Hardwick
New Braintree
North Brookfield
Oakham
Petersham
Phillipston
Royalston
South Barre
Southbridge
Spencer
Sturbridge
Templeton
Warren
West Brookfield
West Warren
Wheelwright
Winchendon

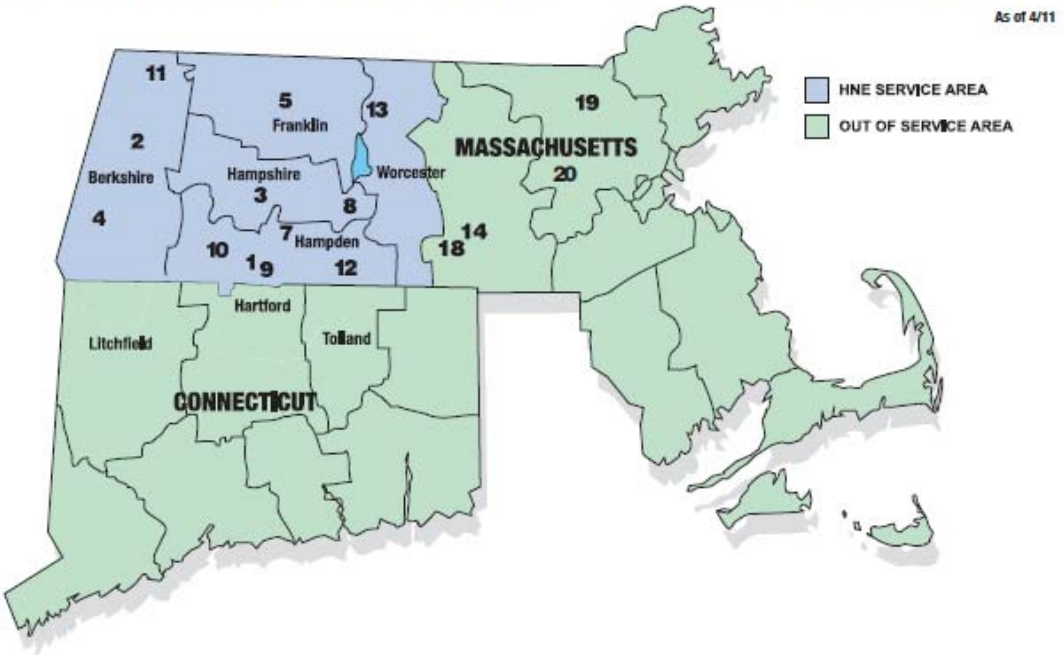
** Health New England serves New York and Connecticut residents (and their dependents) who are employed by Massachusetts companies but is not licensed in those states.*

One Monarch Place, Suite 1500 · Springfield, MA 01144-1500 · 413-233-3535 · 800-842-4464 · hne.com

Coverage Maps

HNE PROVIDER NETWORK - FULLY FUNDED HMO

As of 4/11



HOSPITALS ALPHABETIZED BY TOWN

MASSACHUSETTS

Athol Memorial Hospital (13)
2033 Main St.
Athol, MA 01331
978-249-3511

Lahey Clinic (20)
41 Mall Rd
Burlington, MA 01805
781-744-5100

Fairview Hospital (4)
29 Lewis Ave.
Great Barrington, MA 01230
413-528-0790

Baystate Franklin Medical Center (5)
164 High St.
Greenfield, MA 01301
413-772-0211

Heywood Hospital (19)
242 Green St.
Gardner MA 01440
978-632-3420

Holyoke Medical Center (7)
575 Beech St.
Holyoke, MA 01040
413-534-2500

North Adams Regional Hospital (11)
71 Hospital Ave.
North Adams, MA 01247
413-663-3701

Cooley Dickinson Hospital (3)
30 Locust St.
Northampton, MA 01060
413-582-2000

Wing Memorial Hospital (12)
and affiliated community medical centers
40 Wright St.
Palmer, MA 01069
413-283-7651

Berkshire Medical Center (2)
725 North St.
Pittsfield, MA 01201
413-447-2000

Baystate Medical Center (1)
759 Chestnut St.
Springfield, MA 01199
413-794-0000

Mercy Medical Center (9)
271 Carew St.
Springfield, MA 01104
413-748-9000

Baystate Mary Lane Hospital (8)
85 South St.
Ware, MA 01082
413-967-6211

Noble Hospital (10)
115 W. Silver St.
Westfield, MA 01086
413-568-2811

St Vincent Hospital (18)
123 Summer Street
Worcester, MA 01608
508-363-5000

UMass Memorial Medical Center Campuses (14)
Hahneman Campus
281 Lincoln St.
Worcester, MA 01605
508-334-1000

Memorial Campus
119 Belmont St.
Worcester, MA 01605
508-334-1000

University Campus
55 Lake Ave. North
Worcester, MA 01655
508-334-1000

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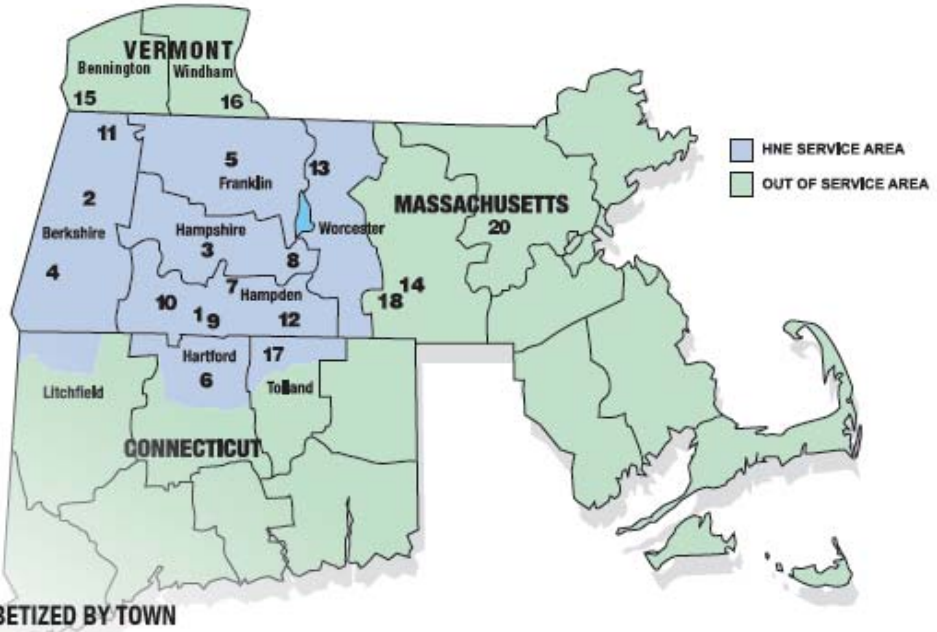
Coverage Maps

HNE PROVIDER NETWORK-FULLY FUNDED PPO PLANS AND SELF FUNDED PLANS

As of 4/11



HOSPITALS ALPHABETIZED BY TOWN

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Athol, MA 01331
978-249-3511

Lahey Clinic (20)
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Burlington, MA 01805
781-744-5100

Heywood Hospital (19)
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119 Belmont St.
Worcester, MA 01605
508-334-1000

University Campus
55 Lake Ave. North
Worcester, MA 01655
508-334-1000

CONNECTICUT

Hartford Hospital (6)
80 Seymour St
Hartford, CT 06115
860-545-5000

Johnson Memorial Hospital (17
201 Chestnut Hill Rd
Stafford Springs, CT 06076
860-684-4251

VERMONT

Southwestern Vermont Medical Center (15)
100 Hospital Dr
Bennington VT 05201
802-442-6361

Brattleboro Memorial Hospital (16)
17 Belmont Ave
Brattleboro, VT 05301
802-257-0341

HNE

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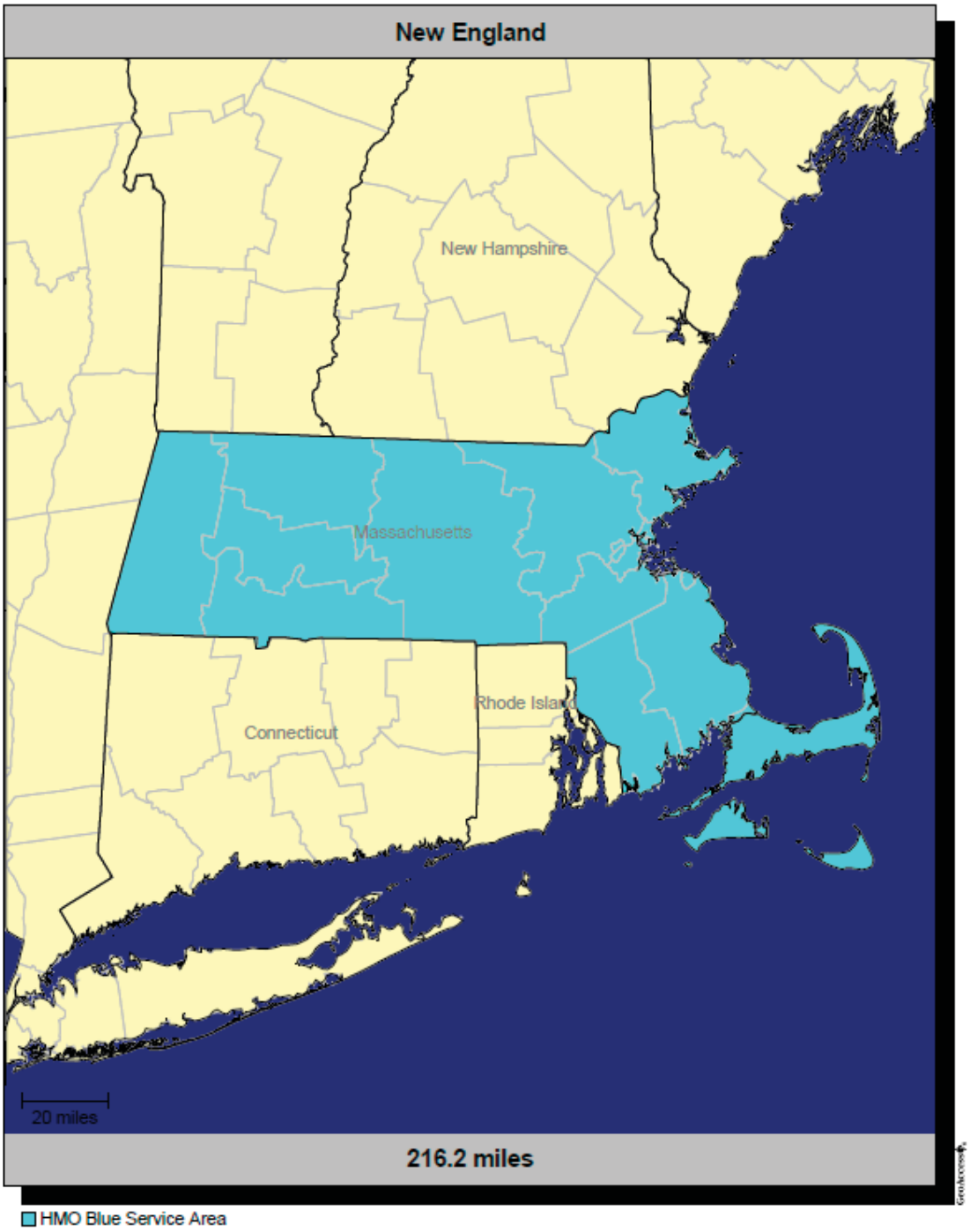
Coverage Maps

HMO Blue® Network

Geographic overview



CITY OF CHICOPEE
HUMAN RESOURCES

274 FRONT STREET, 4TH FLOOR • CHICOPEE, MA 01013
PHONE (413) 594-1510 FAX (413) 594-1513

ACTIVE INSURANCE FORM

PLEASE PRINT CLEARLY

This form is required for new enrollments, additions of dependents, cancellation of coverage or change of personal information in any active employee health plan. Return the form to Human Resources once completed. This form is available online in electronic format at www.ChicopeeMA.gov under Human Resources. Please PRINT clearly. Incomplete or illegible forms will be returned unprocessed.

CHECK ONE: ☐ NEW MEMBER ☐ ADDITION ☐ CANCELLATION ☐ UPDATE INFORMATION

Important: You are required to provide a copy of a marriage certificate, birth certificate, separation agreement, divorce decree, certificate of appointment as legal guardian, etc., for each person you list as a dependent. Failure to provide this documentation will result in your spouse/dependent not being covered. If you are deleting a spouse or dependent under age 19, you must provide proof of other coverage. If you are enrolling with the City of Chicopee due to loss of coverage through a qualifying event, you must provide documentation of the qualifying event.

INSURED INFORMATION

Social Security Number _____ - _____ - _____ Date of Birth _____ / _____ / _____ Gender ☐ M ☐ F

Name

Last First Middle

Address

Number Street Apt. #

( )

City State Zip Primary Phone

Primary Care Provider (Last, First, Middle) PCP Provider ID #

MEMBERSHIP ☐ Individual ☐ Family REQUESTED EFFECTIVE DATE _____ / _____ / _____

HEALTH PLAN (check one)

☐ Health New England Essential 500 ☐ Blue Cross Blue Shield HMO Options

☐ Blue Cross Blue Shield HMO 500 ☐ Health New England Essential 1000 ☐ Blue Cross Blue Shield HMO 1000

☐ Health New England PPO Essential 500 ☐ Health New England WiseMAX

DENTAL PLAN

☐ Blue Cross Blue Shield Dental Blue

SPOUSE/DEPENDENT INFORMATION

List below all family members, including your spouse or former spouse (if eligible), who will be covered under your family plan. If you wish to maintain an INDIVIDUAL plan, leave this part blank. Please provide all Social Security Numbers (required under Federal Law Section 111) and exact dates of birth for each dependent. Attach a separate sheet if needed. To add a dependent age 19 to 26, you must complete a Dependent Age 19 to 26 Enrollment Application.

Last	First	M.I.	Relationship	Sex	Date of Birth	PCP ID #	Social Security Number
				M / F	/ /		- -
				M / F	/ /		- -
				M / F	/ /		- -
				M / F	/ /		- -

I understand that by accepting coverage under this plan, any health care provider may receive, use and disclose my medical information for treatment, payment, health care operations and any and all other uses allowed by law. I certify under the pains and penalties of perjury that all information is complete and accurate. I understand that further plan design and privacy statements can be obtained further by contacting the insurance plan providers.

Signature Date

FOR EMPLOYER USE ONLY Effective Date _____ / _____ / _____ Group # _____ Employer Initial _____

Enrollment ☐ New Enrollment ☐ Open Enrollment ☐ Loss of Insurance / Qualifying Event

Change to Policy ☐ Add Dependent ☐ Terminate Dependent ☐ Name / Address Change ☐ Marriage ☐ COBRA ☐ Change Coverage

Termination of Policy ☐ Left Employment ☐ Voluntary Cancellation ☐ Deceased ☐ Retirement ☐ No Longer Eligible

Notes

HNE Essential[500]

HMO Benefit Chart

This chart provides a summary of key services offered by your plan. Consult your Member Agreement for a full description of your plan's benefits and provisions.

- **Note about Prior Approval:**
  Some services require prior approval. These services are marked with † in the chart**.** If you do not obtain Prior Approval, benefits may be denied.

	In-Plan
Deductible per Year* (You must pay this amount for Covered Services before HNE will begin to pay benefits. As indicated in the chart below, some services are not subject to the Deductible.)	$500 per individual/$1,000 per family
* May be based on a Calendar Year or a Policy Year basis. This depends on the Group through which you enroll.	
Safety Net: You are **protected** by an Out-of-Pocket Maximum each year.* Once you reach this amount you will not have to pay Copays for certain services for the remainder of the year. (Included in your Out-of-Pocket Maximum are: your Deductible and all medical services with a Copay of $100 or more, including Copays for Durable Medical Equipment and Prosthetics.)	$2,000 per individual/$4,000 per family

Benefit	**Deductible Applies**	**Copay**
Inpatient Care		
Acute Hospital Care and Inpatient Rehabilitation	Yes	$0
Skilled Nursing Facility † (limited to 100 days per Calendar Year)	Yes	$0
Outpatient Preventive Care		
Adult Routine Exams	No	$0
Well Child Care	No	$0
Routine Prenatal & Postpartum Care	No	$0
Child and Adult Routine Immunizations	No	$0
Routine Eye Exams (limited to one per Calendar Year)	No	$0
Annual Gynecological Exams (limited to one per Calendar Year)	No	$0
Routine Mammograms (routine mammograms limited to one per Calendar Year)	No	$0
Preventive Screenings Listed under "Outpatient Preventive Care" in the *Covered Benefits* Section of the EOC	No	$0
Other Outpatient Care		
PCP Office Visit (Non-Routine) (Deductible may apply to some office services)	No	$20/visit
Hearing Tests	Yes	$20/visit
Specialist Office Visits (Deductible may apply to some office services)	No	$20/visit
Second Opinions (Deductible may apply to some office services)	No	$20/visit

Benefit	Deductible Applies	Copay
Diabetic-Related Items:		
Outpatient Services (Deductible may apply to some office services)	No	$20/visit
Lab Services	No	$0
Durable Medical Equipment (some DME requires Prior Approval)	No	20%
Individual Diabetic Education	No	$20/visit
Group Diabetic Education	No	$20/session
Autism Spectrum Disorder		
Services to diagnose ASD, This includes:		
• Neuropsychological evaluations †	No	$20/visit
• Genetic testing †	No	$0
• Other tests to diagnose ASD (some tests may require Prior Approval)	Depends on type of test as listed elsewhere in this chart (Lab Services, Diagnostic Imaging, Diagnostic Testing, etc.)	Copay amount depends on type of test as listed elsewhere in this chart (Lab Services, Diagnostic Imaging, Diagnostic Testing, etc.)
Habilitative or Rehabilitative care (includes applied behavioral analysis (ABA)) †	No	$20/visit
Pharmacy care	Medical Deductible does not apply.	Please see the Prescription Drug Rider to your EOC for details about your prescription coverage
Psychiatric care	No	$20/visit
Psychological care	No	$20/visit
Therapeutic care:		
• Services provided by licensed or certified speech therapists, occupational therapists, physical therapists	Yes	$20/visit/ treatment type
• Services provided by licensed or certified social workers	No	$20/visit
Emergency Room Care (Copay waived if admitted)	No	$150/visit
Diagnostic Testing	Yes	$0
Screening Colonoscopy or Sigmoidoscopy (limited to one every five Calendar Years; office visit Copay may apply if done in a doctor's office; office visits prior to the procedure, related prep prescriptions and subsequent pathology are subject to applicable Deductible & Copays)	No	$0
Sleep Study (maximum of two per Calendar Year)	Yes	$75 (one Copay per year; no Copay for home sleep studies)
Lab Services	No	$0
Genetic testing: BRCA and Colaris tests †	Yes	$75
Radiological Services: Ultrasound, X-rays, Non-Routine Mammograms	Yes	$0

Benefit	Deductible Applies	Copay
Diagnostic Imaging: CT Scans, MRIs, MRAs, PET Scans, Nuclear Cardiac Imaging † (Nuclear Cardiac Imaging requires Prior Approval only when done in a doctor's office)	Yes	$75 (maximum three Copays per year)
Outpatient Short-Term Rehabilitation Services (limited to two months or 25 visits, whichever is greater, per condition per Calendar Year for physical or occupational therapy)	Yes	$20/visit per treatment type
Day Rehabilitation Program (limited to 15 full day or ½ day sessions per condition per lifetime)	Yes	$25 for 1 day or 1/2 day
Early Intervention Services (Covered for children from birth to age 3.)	No	$0
Outpatient Surgical Services and Procedures (some services require Prior Approval; office visit Copay may apply if done in a doctor's office)	Yes	$0
Allergy Testing and Treatment	No	$20/visit
Allergy Injections	No	$0
Family Planning Services		
Office Visit (Deductible may apply to some office services)	No	$20/visit
Infertility Services		
Some Infertility services are covered only for Massachusetts residents and for Connecticut residents under the age of 40. Some services require Prior Approval.		
Office Visit (Deductible may apply to some office services)	No	$20/visit
Outpatient Surgery/ Procedure	Yes	$0
Lab Test	No	$0
Inpatient Care †	Yes	$0
Maternity Care		
Non-Routine Prenatal and Postpartum Care	No	$20/visit
Delivery/Hospital Care for Mother and Child (Coverage for child limited to routine newborn nursery charges. For continued coverage, child must be enrolled within 31 days of date of birth.)	Yes	$0
Dental Services		
Surgical Treatment of Non-Dental Conditions in a Doctor's Office (Some services are subject to the Outpatient Surgical Services and Procedures Copay. Deductible may apply to some office services.)	No	$20/visit
Emergency Dental Care in a Doctor's or Dentist's Office	No	$20/visit
Emergency Dental Care in an Emergency Room	No	$150/visit
Routine dental services for children under the age of 12. (A separate $25 per child per Calendar Year deductible applies only to services from Out-of-Plan dentists. Out-of-Plan dentists may also bill you for the difference between their charge and HNE's contracted dental network Maximum Allowable Fee.)	No	$0
Other Services		
Home Health Care †	Yes	$0
Hospice Services †	No	$0

Benefit	Deductible Applies	Copay
Durable Medical Equipment (some items require Prior Approval)	No	20%
Prosthetic Limbs †	No	20%
Ambulance and Transportation Services (non-emergency transportation requires Prior Approval)	Yes	$100/Member/day
Kidney Dialysis	No	$0
Nutritional Support †	No	$0
Cardiac Rehabilitation	Yes	$20/visit
Wigs (Scalp Hair Prostheses) for hair loss due to treatment of any form of cancer or leukemia. (HNE pays up to $350 per Calendar Year)	No	$0
Speech, Hearing, and Language Disorders † (Prior Approval is required for speech therapy services after the initial evaluation)	Yes	$20/visit
Nutritional Counseling (maximum of 4 visits per Calendar Year)	No	$0
Human Organ Transplants and Bone Marrow Transplants †	Yes	$0
Behavioral Health		
Outpatient Services (Includes Mental Health and Substance Abuse)	No	$20/visit
Inpatient Services (Includes Mental Health and Substance Abuse)	Yes	$0

E500-1/1/11

Your Prescription Drug Copays

Your Prescription Benefit is based on the HNE Formulary. Please call Member Services or visit hne.com for a copy of the HNE Formulary.

From a Pharmacy

The Copays for up to a 30-day supply of prescription drugs received from an In-Plan pharmacy are as follows:

	In-Plan
Generic	$10
Brand Name (Formulary)	$25
Brand Name (Non-Formulary)	$45

Mail Order Prescriptions

The Copays for a 90-day supply of maintenance medications through HNE's participating mail order supplier are as follows:

	In-Plan
Generic	$10
Brand Name (Formulary)	$25
Brand Name (Non-Formulary)	$45

Chiropractic Services Amendment	**HMO Office Visit Copayment: $10**
This is an Amendment to your Health New England, Inc. Explanation of Coverage ("EOC"). Please keep this Amendment with your EOC as it changes the terms of that document. If specific terms of this Amendment differ from the terms of the EOC, the terms of this Amendment apply. Your EOC is amended regarding chiropractic services, as shown below. This benefit is administered by OptumHealth Care Solutions, HNE's chiropractic services manager.	
What your plan covers	• We cover up to 12 visits per year for medically necessary chiropractic services. • When you receive services, your In-Plan chiropractor must notify OptumHealth Care Solutions. OptumHealth Care Solutions will work with your In-Plan chiropractor to determine the appropriate level of covered services to treat your condition. If your chiropractor does not notify OptumHealth Care Solutions, you will not be held financially liable for the services. • HNE will cover your visits with an In-Plan chiropractor. A $10 copayment applies for each visit.
Exclusions	• Maintenance care (Care given to reduce the incidence or prevalence of illness, impairment, or risk factors, or to promote optimum function) • Orthotics • Services that are not medically necessary • Services with an Out-of-Plan chiropractor • Exclusions or limitations included in the EOC
For more information or to find a provider	*On the web:* • Visit www.hne.com *On the phone:* • Call HNE Member Services at 413-787-4004 or 800-310-2835 • Call OptumHealth Care Solutions at 888-676-7768 *Listings are subject to change without notice. Chiropractors are not contracted or credentialed by Health New England.*

HNE Wise^{Max} (HDHP HMO H)

High Deductible Health Plan HMO Benefit Chart

This chart provides a summary of key services offered by your plan. Consult your Member Agreement for a full description of your plan's benefits and provisions.

- **Note about Prior Approval:**
  Some services require prior approval. These services are marked with † in the chart**.** If you do not obtain Prior Approval, benefits may be denied.

	In-Plan
Combined Medical/Pharmacy Deductible per Year * (You must pay this amount for Covered Services before HNE will begin to pay benefits. As indicated in the chart below, some services are not subject to the Deductible. If your plan includes prescription drug coverage, your prescriptions are subject to this Deductible.)	$2,000 per individual/$4,000 per family**
* May be based on a Calendar Year or a Policy Year basis. This depends on the Group through which you enroll.	
Safety Net: You are **protected** by an Out-of-Pocket Maximum each year.* Once you reach this amount you will not have to pay Copays for the remainder of the year. (Included in your Out-of-Pocket Maximum are: your Deductible and all Copays. If your plan has prescription drug coverage, your Copays for prescriptions are included in this Out-of-Pocket Maximum.)	$5,000 per individual/$10,000 per family
** Once any individual on a family plan has paid $2,400 towards the family Deductible, the plan will begin to pay benefits for that individual.	

Benefit	**Deductible Applies**	**Copay**
Inpatient Care		
Acute Hospital Care and Inpatient Rehabilitation	Yes	$0
Skilled Nursing Facility † (limited to 100 days per Calendar Year)	Yes	$0
Outpatient Preventive Care		
Adult Routine Exams	No	$0
Well Child Care	No	$0
Routine Prenatal & Postpartum Care	No	$0
Child and Adult Routine Immunizations	No	$0
Routine Eye Exams (limited to one per Calendar Year)	No	$0
Annual Gynecological Exams (limited to one per Calendar Year)	No	$0
Routine Mammograms (routine mammograms limited to one per Calendar Year)	No	$0
Preventive Screenings Listed under "Outpatient Preventive Care" in the *Covered Benefits* Section of the EOC	No	$0
Other Outpatient Care		
PCP Office Visit (Non-Routine)	Yes	$0
Specialist Office Visits	Yes	$0
Hearing Tests	Yes	$0

Benefit	Deductible Applies	Copay
Second Opinions	Yes	$0
Diabetic-Related Items:		
Outpatient Services	Yes	$0
Lab/Radiological Services	Yes	$0
Durable Medical Equipment (some DME requires Prior Approval)	Yes	$0
Individual Diabetic Education	No	$0
Group Diabetic Education	No	$0
Autism Spectrum Disorder		
Services to diagnose ASD, This includes:		
• Neuropsychological evaluations †	Yes	$0
• Genetic testing †	Yes	$0
• Other tests to diagnose ASD (some tests may require Prior Approval)	Yes	Copay amount depends on type of test as listed elsewhere in this chart (Lab Services, Diagnostic Imaging, Diagnostic Testing, etc.)
Habilitative or Rehabilitative care (includes applied behavioral analysis (ABA)) †	Yes	$0
Pharmacy care	Yes	Please see the Prescription Drug Rider to your EOC for details about your prescription coverage
Psychiatric care	Yes	$0
Psychological care	Yes	$0
Therapeutic care:		
• Services provided by licensed or certified speech therapists, occupational therapists, physical therapists	Yes	$0
• Services provided by licensed or certified social workers	Yes	$0
Emergency Room Care (Copay waived if admitted)	Yes	$0
Diagnostic Testing	Yes	$0
Screening Colonoscopy or Sigmoidoscopy (limited to one every five Calendar Years; office visit Copay may apply if done in a doctor's office; office visits prior to the procedure, related prep prescriptions and subsequent pathology are subject to applicable Deductible & Copays)	No	$0
Sleep Study (maximum of two per Calendar Year)	Yes	$0
Lab Services	Yes	$0
Genetic testing: BRCA and Colaris tests †	Yes	$0
Radiological Services: Ultrasound, X-rays, Non-Routine Mammograms	Yes	$0

Benefit	Deductible Applies	Copay
Diagnostic Imaging: CT Scans, MRIs, MRAs, PET Scans, Nuclear Cardiac Imaging † (Nuclear Cardiac Imaging requires Prior Approval only when done in a doctor's office)	Yes	$0
Outpatient Short-Term Rehabilitation Services (limited to two months or 25 visits, whichever is greater, per condition per Calendar Year for physical or occupational therapy)	Yes	$0
Day Rehabilitation Program (limited to 15 full of half day sessions per condition per lifetime)	Yes	$0
Early Intervention Services (Covered for children from birth to age 3.)	Yes	$0
Outpatient Surgical Services and Procedures (some services require Prior Approval; office visit Copay may apply if done in a doctor's office)	Yes	$0
Allergy Testing and Treatment	Yes	$0
Allergy Injections	Yes	$0
Family Planning Services		
Office Visit	Yes	$0
Infertility Services		
Some Infertility services are covered only for Massachusetts residents and for Connecticut residents under the age of 40. Some services require Prior Approval.		
Office Visit	Yes	$0
Outpatient Surgery/ Procedure	Yes	$0
Lab Test	Yes	$0
Inpatient Care †	Yes	$0
Maternity Care		
Non-Routine Prenatal and Postpartum Care	Yes	$0
Delivery/Hospital Care for Mother and Child (For continued coverage, child must be enrolled within 31 days of date of birth)	Yes	$0
Dental Services		
Surgical Treatment of Non-Dental Conditions in a Doctor's Office (Some services are subject to the Outpatient Surgical Services and Procedures Copay.)	Yes	$0
Emergency Dental Care in a Doctor's or Dentist's Office	Yes	$0
Emergency Dental Care in an Emergency Room	Yes	$0
Routine dental services for children under the age of 12. (A separate $25 per child per Calendar Year deductible applies only to services from Out-of-Plan dentists. This does not count toward your Medical/Pharmacy Deductible. Out-of-Plan dentists may also bill you for the difference between their charge and HNE's contracted dental network Maximum Allowable Fee.)	No	$0
Other Services		
Home Health Care †	Yes	$0
Hospice Services †	Yes	$0

Benefit	Deductible Applies	Copay
Durable Medical Equipment (some items require Prior Approval)	Yes	$0
Prosthetic Limbs †	Yes	$0
Ambulance and Transportation Services (non-emergency transportation requires Prior Approval)	Yes	$0
Kidney Dialysis	Yes	$0
Nutritional Support †	Yes	$0
Cardiac Rehabilitation	Yes	$0
Wigs (Scalp Hair Prostheses) for hair loss due to treatment of any form of cancer or leukemia. (HNE pays up to $350 per Calendar Year)	Yes	$0
Speech, Hearing, and Language Disorders † (Prior Approval is required for speech therapy services after the initial evaluation.)	Yes	$0
Nutritional Counseling (limited to four visits per Calendar Year)	No	$0
Non-Routine Immunizations	Yes	$0
Human Organ Transplants and Bone Marrow Transplants †	Yes	$0
Behavioral Health		
Outpatient Services (Includes Mental Health and Substance Abuse)	Yes	$0
Inpatient Services (Includes Mental Health and Substance Abuse)	Yes	$0

Your Prescription Drug Copays

Your Prescription Benefit is based on the HNE Formulary. Please call Member Services or visit hne.com for a copy of the HNE Formulary.

Deductible

The High Deductible Health Plan (HDHP) combined medical/pharmacy Deductible applies to all prescription drugs.

From a Pharmacy

After the Deductible has been satisfied, you pay the Copays shown below. Each Copay is for up to a 30-day supply of prescription drugs from an In-Plan pharmacy.

	Deductible Applies	**In-Plan**
Generic	Yes	$10
Brand Name (Formulary)	Yes	$25
Brand Name (Non-Formulary)	Yes	$45

Mail Order Prescriptions

After the Deductible has been satisfied, you pay the Copays show below. Each Copay is for a 90-day supply of maintenance medications from HNE's participating mail order supplier.

	Deductible Applies	**In-Plan**
Generic	Yes	$10
Brand Name (Formulary)	Yes	$25
Brand Name (Non-Formulary)	Yes	$45

HNE PPO Essential[500-National]

PPO Benefit Chart

This chart provides a summary of key services offered by your plan. Consult your Member Agreement for a full description of your plan's benefits and provisions.

- Please note: for Out-of-Plan services, you are also responsible for any Remaining Balances. A Remaining Balance is that portion of an Out-of-Plan Provider's charge that is above HNE's Maximum Allowable Fee.
- Note about Prior Approval:
  Some services require Prior Approval. These services are marked with † in the chart. In some cases, if you fail to ask for Prior Approval the service will not be covered at all. (See, for example, Infertility Treatment below.) In other cases, for example Acute Hospital Care at an Out-of-Plan facility, if you fail to ask for Prior Approval you may have a Reduction of Benefit up to the amount indicated below. Remember that exclusions or limitations of this plan still apply, even if you ask for Prior Approval. For example, services that are not Medically Necessary are not covered, even if you ask for Prior Approval.

	In-Plan Providers		Out-of-Plan Providers
	HNE Providers	**PHCS Providers**	
Deductible per Year* (You must pay this amount for Covered Services before HNE will begin to pay benefits. This is a combined amount for HNE, PHCS, and Out-of-Plan providers. As indicated in the chart below, some services are not subject to the Deductible.)	$500 per individual/$1,000 per family	$500 per individual/$1,000 per family	$500 per individual/$1,000 per family
Safety Net for In-Plan Services: You are **protected** by a Copay Maximum each year.* Once you reach this amount you will not have to pay Copays for certain In-Plan services for the remainder of the year. (This applies to all medical services with a Copay of $100 or more, including Copays for Durable Medical Equipment and Prosthetics.) This is a combined amount for HNE & PHCS Providers.	$1,500 per individual/$3,000 per family	$1,500 per individual/$3,000 per family	Not applicable
Coinsurance Maximum per Year*	Not applicable	Not applicable	$1,500 per individual/$3,000 per family
* May be based on a Calendar Year or a Policy Year basis. This depends on the Group through which you enroll.			

	In-Plan Providers		Out-of-Plan Providers
	HNE Providers	PHCS Providers	
Reduction of Benefit (Applies to certain services if Prior Approval is required but not requested.)	Not applicable	$500	$500

Benefit	In-Plan			Out-of-Plan Providers	
	Deductible Applies	HNE Providers Copay	PHCS Providers Copay	Deductible Applies	Coinsurance or Copay
Inpatient Care					
Acute Hospital Care and Inpatient Rehabilitation † (elective admissions to Out-of-Plan facilities require Prior Approval)	Yes	$0	$0 & up to $500 Reduction of Benefit	Yes	20% & up to $500 Reduction of Benefit
Skilled Nursing Facility † (limited to 100 days per Calendar Year; admissions to Out-of-Plan Facilites require Prior Approval)	Yes	$0	$0 & up to $500 Reduction of Benefit	Yes	20% & up to $500 Reduction of Benefit
Outpatient Preventive Care					
Adult Routine Exams	No	$0	$0	Yes	20%
Well Child Care	No	$0	$0	Yes	20%
Routine Prenatal & Postpartum Care	No	$0	$0	Yes	20%
Child and Adult Routine Immunizations	No	$0	$0	Yes	20%
Routine Eye Exams (limited to one per Calendar Year)	No	$0	$0	Yes	20%
Annual Gynecological Exams (limited to one per Calendar Year)	No	$0	$0	Yes	20%
Routine Mammograms (routine mammograms limited to one per Calendar Year)	No	$0	$0	Yes	20%
Preventive Screenings Listed under "Outpatient Preventive Care" in the *Covered Benefits* Section of the EOC	No	$0	$0	Yes	20%
Other Outpatient Care					
Physician Office Visit (Deductible may apply to some In-Plan office services.)	No	$20/visit	$20/visit	Yes	20%
Second Opinions (Deductible may apply to some In-Plan office services.)	No	$20/visit	$20/visit	Yes	20%
Hearing Tests	Yes	$20/visit	$20/visit	Yes	20%

Benefit	In-Plan			Out-of-Plan Providers	
	Deductible Applies	**HNE Providers Copay**	**PHCS Providers Copay**	**Deductible Applies**	**Coinsurance or Copay**
Diabetic-Related Items:					
Outpatient Services (Deductible may apply to some In-Plan office services.)	No	$20/visit	$20/visit	Yes	20%
Lab Services	No	$0	$0	Yes	20%
Durable Medical Equipment (some DME requires Prior Approval)	No	20%	20% & if Prior Approval was required and not requested, up to $500 Reduction of Benefit	Yes	20% & if Prior Approval was required and not requested, up to $500 Reduction of Benefit
Individual Diabetic Education	No	$20/visit	$20/visit	Yes	20%
Group Diabetic Education	No	$20/visit	$20/visit	Yes	20%
Autism Spectrum Disorder					
Services to diagnose ASD, This includes:					
• Neuropsychological evaluations †	No	$20/visit	$20/visit & up to $500 Reduction of Benefit	Yes	Deductible + 20% & up to $500 Reduction of Benefit
• Genetic testing †	No	$0	$0 & up to $500 Reduction of Benefit	Yes	Deductible + 20% & up to $500 Reduction of Benefit
• Other tests to diagnose ASD (some tests may require Prior Approval)	Depends on type of test as listed elsewhere in this chart (Lab Services, Diagnostic Imaging, Diagnostic Testing, etc.)	Copay amount depends on type of test as listed elsewhere in this chart (Lab Services, Diagnostic Imaging, Diagnostic Testing, etc.)	Copay amount depends on type of test as listed elsewhere in this chart (Lab Services, Diagnostic Imaging, Diagnostic Testing, etc.)	Yes	Deductible + 20%
Habilitative or Rehabilitative care (includes applied behavioral analysis (ABA)) †	No	$20/visit	$20/visit & up to $500 Reduction of Benefit	Yes	Deductible + 20% & up to $500 Reduction of Benefit

Benefit	In-Plan			Out-of-Plan Providers	
	Deductible Applies	**HNE Providers Copay**	**PHCS Providers Copay**	**Deductible Applies**	**Coinsurance or Copay**
Pharmacy care	Medical Deductible does not apply	Please see the Prescription Drug Rider to your EOC for details about your prescription coverage		Medical Deductible does not apply	Please see the Prescription Drug Rider to your EOC for details about your prescription coverage
Psychiatric care	No	$20/visit	$20/visit	Yes	Deductible + 20%
Psychological care	No	$20/visit	$20/visit	Yes	Deductible + 20%
Therapeutic care:					
• Services provided by licensed or certified speech therapists, occupational therapists, physical therapists	Yes	$20/visit/ treatment type	$20/visit/ treatment type	Yes	Deductible + 20%
• Services provided by licensed or certified social workers	No	$20/visit	$20/visit	Yes	Deductible + 20%
Emergency Room Care (Copay waived if admitted)	No	$150/visit	$150/visit	No	$150/visit
Diagnostic Testing	Yes	$0	$0	Yes	20%
Screening Colonoscopy or Sigmoidoscopy (limited to one every five Calendar Years; office visit Copay may apply if done in an In-Plan doctor's office; office visits prior to the procedure, related prep prescriptions and subsequent pathology are subject to applicable Deductible & Copays)	No	$0	$0	Yes	20%
Sleep Study (maximum of two per Calendar Year)	Yes	$75 (one Copay per year; no Copay for home sleep studies)	$75 (one Copay per year; no Copay for home sleep studies)	Yes	20%
Lab Services	No	$0	$0	Yes	20%
Genetic testing: BRCA and Colaris tests †	Yes	$75	$75 & up to $500 Reduction of Benefit	Yes	20% & up to $500 Reduction of Benefit
Radiological Services: Ultrasound, X-rays, Non-Routine Mammograms	Yes	$0	$0	Yes	20%

Benefit	In-Plan			Out-of-Plan Providers	
	Deductible Applies	**HNE Providers Copay**	**PHCS Providers Copay**	**Deductible Applies**	**Coinsurance or Copay**
Diagnostic Imaging: CT Scans, MRIs, MRAs, PET Scans, Nuclear Cardiac Imaging † (Nuclear Cardiac Imaging requires Prior Approval only when done in a doctor's office)	Yes	$75 (maximum three Copays per year; if Prior Approval is denied, Member is responsible for all costs)	$75 (maximum three Copays per year; without Prior Approval, Member pays all costs)	Yes	20% (without Prior Approval, Member pays all costs)
Outpatient Short-Term Rehabilitation Services (limited to two months or 25 visits, whichever is greater, per condition per Calendar Year for physical or occupational therapy)	Yes	$20/visit per treatment type	$20/visit per treatment type	Yes	20%
Day Rehabilitation Program (limited to 15 full day or ½ day sessions per condition per lifetime)	Yes	$25 for 1 day or 1/2 day	$25 for 1 day or 1/2 day	Yes	20%
Early Intervention Services (Covered for children from birth to age 3.)	No	$0	$0	Yes	20%
Outpatient Surgical Services and Procedures (some services require Prior Approval; office visit Copay may apply if done in an In-Plan doctor's office)	Yes	$0	$0	Yes	20%
Allergy Testing and Treatment	No	$20/visit	$20/visit	Yes	20%
Allergy Injections	No	$0	$0	Yes	20%
Family Planning Services					
Office Visit (Deductible may apply to some In-Plan office services)	No	$20/visit	$20/visit	Yes	20%
Infertility Services					
Some Infertility services are covered only for Massachusetts residents and for Connecticut residents under the age of 40. Some services require Prior Approval.					
Office Visit (Deductible may apply to some In-Plan office services)	No	$20/visit	$20/visit (if Prior Approval is required & not requested, Member pays all costs)	Yes	20% (if Prior Approval is required & not requested, Member pays all costs)

Benefit	In-Plan			Out-of-Plan Providers	
	Deductible Applies	**HNE Providers Copay**	**PHCS Providers Copay**	**Deductible Applies**	**Coinsurance or Copay**
Outpatient Surgery/ Procedure	Yes	$0	$0 (if Prior Approval is required & not requested, Member pays all costs)	Yes	20% (if Prior Approval, is required & not requested, Member pays all costs)
Lab Test	No	$0	$0 (if Prior Approval is required & not requested, Member pays all costs)	Yes	20% (if Prior Approval, is required & not requested, Member pays all costs)
Inpatient Care †	Yes	$0	$0 (if Prior Approval is required & not requested, Member pays all costs)	Yes	20% (without Prior Approval, Member pays all costs)
Maternity Care					
Non-Routine Prenatal and Postpartum Care	No	$20/visit	$20/visit	Yes	20%
Delivery/Hospital Care for Mother and Child (Coverage for child limited to routine newborn nursery charges. For continued coverage, child must be enrolled within 31 days of date of birth)	Yes	$0	$0	Yes	20%
Dental Services					
Surgical Treatment of Non-Dental Conditions in a Doctor's Office (Deductible may apply to some In-Plan office services.)	No	$20/visit	$20/visit	Yes	20%
Emergency Dental Care in a Doctor's or Dentist's Office	No	$20/visit	$20/visit	Yes	20%
Emergency Dental Care in an Emergency Room	No	$150/visit	$150/visit	No	$150/visit

Benefit	In-Plan			Out-of-Plan Providers	
	Deductible Applies	**HNE Providers Copay**	**PHCS Providers Copay**	**Deductible Applies**	**Coinsurance or Copay**
Routine dental services for children under the age of 12. (A separate $25 per child per Calendar Year deductible applies only to services from Out-of-Plan dentists. This does not count towards your Deductible. Out-of-Plan dentists may also bill you for the difference between their charge and HNE's contracted dental network Maximum Allowable Fee.)	No	$0 for services from a dentist participating with HNE's contracted dental network	$0 for services from a dentist participating with HNE's contracted dental network	No	You pay the first $25 per child per Calendar Year
Other Services					
Home Health Care †	Yes	$0	$0 & up to $500 Reduction of Benefit	Yes	20% & up to $500 Reduction of Benefit
Hospice Services †	No	$0	$0 & up to $500 Reduction of Benefit	Yes	20% & up to $500 Reduction of Benefit
Durable Medical Equipment (some items require Prior Approval)	No	20%	20% & if Prior Approval was required & not requested, up to $500 Reduction of Benefit	Yes	20% & if Prior Approval was required & not requested, up to $500 Reduction of Benefit
Prosthetic Limbs †	No	20%	20% (without Prior Approval, Member pays all costs)	Yes	20% (without Prior Approval, Member pays all costs)
Ambulance and Transportation Services (non-emergency transportation requires Prior Approval; if Prior Approval is not obtained for non-emergency transportation, Member pays all costs)	Yes	$100/ Member/day	$100/Member /day	Yes	$100/Member/ day
Kidney Dialysis	No	$0	$0	Yes	20%
Nutritional Support † (not covered without Prior Approval)	No	$0	$0	No	$0
Cardiac Rehabilitation	Yes	$20/visit	$20/visit	Yes	20%

Benefit	In-Plan			Out-of-Plan Providers	
	Deductible Applies	**HNE Providers Copay**	**PHCS Providers Copay**	**Deductible Applies**	**Coinsurance or Copay**
Wigs (Scalp Hair Prostheses) for hair loss due to treatment of any form of cancer or leukemia. (HNE pays up to $350 per Calendar Year)	No	$0	$0	No	$0
Speech, Hearing, and Language Disorders † (Prior Approval is required for speech therapy services after the initial evaluation.)	Yes	$20/visit	$20/visit & up to $500 Reduction of Benefit	Yes	20% & up to $500 Reduction of Benefit
Nutritional Counseling (limited to four vists per Calendar Year)	No	$0	$0	Yes	20%
Human Organ Transplants and Bone Marrow Transplants † (Without Prior Approval, payments you make to Out-of-Plan Providers for Deductible and Coinsurance do not count toward your Deductible or Maximum Coinsurance amounts.)	Yes	$0	$0 & up to $500 Reduction of Benefit	Yes	20% & up to $500 Reduction of Benefit
Behavioral Health					
Outpatient Services (Includes Mental Health and Substance Abuse; Prior Approval is required for services from Out-of-Plan Providers after the 15th visit)	No	$20/visit	$20/visit	Yes	20%
Inpatient Services (Includes Mental Health and Substance Abuse)	Yes	$0	$0 & up to $500 Reduction of Benefit	Yes	20% & up to $500 Reduction of Benefit

Your Prescription Drug Copays

Your Prescription Benefit is based on the HNE Formulary. Please call Member Services or visit hne.com for a copy of the HNE Formulary.

From a Pharmacy

The Copays for up to a 30-day supply of prescription drugs received from an In-Plan pharmacy are as follows:

	In-Plan
Generic	$10
Brand Name (Formulary)	$25
Brand Name (Non-Formulary)	$45

Mail Order Prescriptions

The Copays for a 90-day supply of maintenance medications through HNE's participating mail order supplier are as follows:

	In-Plan
Generic	$10
Brand Name (Formulary)	$25
Brand Name (Non-Formulary)	$45

Chiropractic Services Amendment	**PPO Plans Office Visit Copayment: $10**
This is an Amendment to your Health New England, Inc. Explanation of Coverage ("EOC"). Please keep this Amendment with your EOC as it changes the terms of that document. If specific terms of this Amendment differ from the terms of the EOC, the terms of this Amendment apply. Your EOC is amended regarding chiropractic services, as shown below. This benefit is administered by OptumHealth Care Solutions, HNE's chiropractic services manager.	
What your plan covers	We cover up to 12 visits per year for medically necessary chiropractic services.
In-Network option	• When you receive services, your In-Network chiropractor must notify OptumHealth Care Solutions. OptumHealth Care Solutions will work with your In-Network chiropractor to determine the appropriate level of covered services to treat your condition. If your chiropractor does not notify OptumHealth Care Solutions, you will not be held financially liable for the services. • HNE will cover your visits with an In-Network chiropractor. A $10 copayment applies for each visit.
Out-of-Network option	• You may visit any chiropractor, but your level of coverage will be higher and costs lower when you use In-Network providers. • When you use Out-of-Network providers: o You pay your copayment. After you pay your copayment, OptumHealth Care Solutions will pay 80 percent of its maximum allowable fee. You are responsible for any remaining balance. o After you receive services from an Out-of-Network chiropractor, OptumHealth Care Solutions may review claims information submitted for those services. Then, OptumHealth Care Solutions will work with your Out-of-Network chiropractor to determine the appropriate level of covered services to treat your condition. o Chiropractic care does not count toward your deductible or out-of-pocket maximum.
Exclusions	• Maintenance Care (Care given to reduce the incidence or prevalence of illness, impairment, and risk factors, and to promote optimum function) • Orthotics • Services that are not medically necessary • Exclusions or limitations included in the EOC
For more information or to find a provider	*On the web:* • Visit www.hne.com *On the phone:* • Call HNE Member Services at 413-787-4004 or 800-310-2835 • Call OptumHealth Care Solutions at 888-676-7768 *Listings are subject to change without notice. Chiropractors are not contracted or credentialed by Health New England.*

If you are a Health New England member, did you know…

You can save money on your prescriptions
If you take prescription drugs for a long term condition (high blood pressure, allergies, etc.), you can save a considerable amount of money by ordering your prescriptions through mail order. For example, a 30 day supply of medication may cost you $10.00. Through mail order, a 90 day supply of the same medicine may cost you the same amount of money! Once you begin mail order, you can conveniently order refills by phone or on line. No more waiting in line at your pharmacy!

All Health New England members are entitled to the Healthy Directions program
Healthy Directions is a great resources for information, discounts and coupons to help you make healthy choices. There is a wellness benefit which allows you up to $150.00 toward the membership at health clubs, enrollment in Weight Watchers or reimbursement for school and town sports registration. There is also an online fitness expert to help you with information about exercise and staying active. When it comes to nutrition, eating a well-balanced diet is a simple way to avoid your risk of many health problems. Healthy Directions has an online grocery store tour, healthy recipes and discounts at participating restaurants to help you make healthy choices when eating out.

As a Health New England member you can participate in the HNE Plus Program
The HNE Plus discount program helps develop your mind, body and spirit. Your HNE membership card entitles you to discounts on healthy lifestyle programs such as alternative medicine, arts & entertainment discounts, beauty and spa treatments, financial and legal services, home and family discounts, sports and outdoor equipment and discounts for local attractions such as Look Park, the Springfield Museums and Peter Pan Bus Lines. HNE also offers discount coupons for Bright Nights and City Stage. For more information, call 1-413-787-4004.

You can take a confidential online health assessment for free
Most people know that genetics and environment can impact their health. But few realize that behavior has the most impact of all. HNE's Health Assessment can help you understand the relationship between your behaviors and your health. Simply complete and submit the questionnaire to receive a Personal Plan for Healthy Living built specifically for you. Your plan will identify behaviors that need improvement and provide the tools for making healthy changes.

If your child is under 12, they can receive routine dental services Health New England has teamed with Altus Dental, the fastest growing dental provider in Massachusetts, to provide children under the age of 12 with routine dental care as long as you use a dentist from the Altus network. If you go out of network, a separate $25 per child per calendar year deductible applies. You can check out the dental network at www.altusdental.com.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.bluecrossma.com or by calling **1-800-932-8323**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	No.	There's no limit on how much you could pay during a coverage period for your share of the cost of covered services.
What is not included in the out-of-pocket limit?	This plan has no **out-of-pocket limit**.	Not applicable because there's no **out-of-pocket limit** on your expenses.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.bluecrossma.com/findadoctor **or call 1-800-821-1388** for a list of network providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** (or provider's charge if it is less than the **allowed amount**) for the service. For example, if the plan's **allowed amount** for an overnight stay is $1,000 (and it is less than the provider's charge), your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network enhanced benefits tier **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts. (If you are eligible to elect a Health Reimbursement Account (HRA), Flexible Spending Account (FSA) or you have elected a Health Savings Account (HSA), you may have access to additional funds to help cover certain **out-of-pocket** expenses such as **copayments**, **coinsurance**, **deductibles** and costs related to services not otherwise covered.)

Common Medical Event	Services You May Need	Your cost if you use				Limitations & Exceptions
		Enhanced Benefits Tier	Standard Benefits Tier	Basic Benefits Tier	Out-of-Network	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 / visit	$25 / visit	$45 / visit	Not covered	——— none ———
	Specialist visit	$45 / visit	$45 / visit	$45 / visit	Not covered	——— none ———
	Other practitioner office visit	$45 / chiropractor visit	$45 / chiropractor visit	$45 / chiropractor visit	Not covered	Limited to 12 visits per calendar year for age 16 and older
	Preventive care/screening/immunization	No charge	No charge	No charge	Not covered	GYN exam limited to one exam per calendar year
If you have a test	Diagnostic test (x-ray, blood work)	No charge	No charge	No charge	Not covered	——— none ———
	Imaging (CT/PET scans, MRIs)	$75	$75 ($150 for hospitals)	$75 ($250 for hospitals)	Not covered	Copayment applies per category of test / day; pre-authorization required for certain services

Common Medical Event	Services You May Need	Your cost if you use				Limitations & Exceptions
		Enhanced Benefits Tier	Standard Benefits Tier	Basic Benefits Tier	Out-of-Network	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bluecrossma.com.	Generic drugs	$15 / retail or $30 / mail service supply	$15 / retail or $30 / mail service supply	$15 / retail or $30 / mail service supply	Not covered	Up to 30-day retail (90-day mail service) supply; cost share waived for birth control; pre-authorization required for certain drugs
	Preferred brand drugs	$30 / retail or $60 / mail service supply	$30 / retail or $60 / mail service supply	$30 / retail or $60 / mail service supply	Not covered	Up to 30-day retail (90-day mail service) supply; pre-authorization required for certain drugs
	Non-preferred brand drugs	$50 / retail or $100 / mail service supply	$50 / retail or $100 / mail service supply	$50 / retail or $100 / mail service supply	Not covered	Up to 30-day retail (90-day mail service) supply; pre-authorization required for certain drugs
	Specialty drugs	$30 / supply	$30 / supply	$30 / supply	Not covered	Up to 30-day supply; pre-authorization required for certain drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$150 / admission	$150 / admission ($250 for hospitals)	$150 / admission ($500 for hospitals)	Not covered	Pre-authorization required for certain services
	Physician/surgeon fees	No charge	No charge	No charge	Not covered	Pre-authorization required for certain services
If you need immediate medical attention	Emergency room services	$100 / visit	$100 / visit	$100 / visit	$100 / visit	——— none ———
	Emergency medical transportation	No charge	No charge	No charge	No charge	——— none ———
	Urgent care	$45 / visit	$45 / visit	$45 / visit	$45 / visit	Out-of-network coverage limited to out of service area

Common Medical Event	Services You May Need	Your cost if you use				Limitations & Exceptions
		Enhanced Benefits Tier	Standard Benefits Tier	Basic Benefits Tier	Out-of-Network	
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 / admission	$500 / admission ($300 for selected hospitals)	$1,000 / admission	Not covered	Pre-authorization required
	Physician/surgeon fee	No charge	No charge	No charge	Not covered	Pre-authorization required
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$15 / visit	$15 / visit	$15 / visit	Not covered	Pre-authorization required for certain services
	Mental/Behavioral health inpatient services	$250 / admission	$250 / admission ($500 for general hospitals)	$250 / admission ($1,000 for general hospitals)	Not covered	Pre-authorization required
	Substance use disorder outpatient services	$15 / visit	$15 / visit	$15 / visit	Not covered	Pre-authorization required for certain services
	Substance use disorder inpatient services	$250 / admission	$250 / admission ($500 for general hospitals)	$250 / admission ($1,000 for general hospitals)	Not covered	Pre-authorization required

Common Medical Event	Services You May Need	Your cost if you use				Limitations & Exceptions
		Enhanced Benefits Tier	Standard Benefits Tier	Basic Benefits Tier	Out-of-Network	
If you are pregnant	Prenatal and postnatal care	No charge	No charge	No charge	Not covered	Applies only to prenatal care
	Delivery and all inpatient services	$250 / admission and no charge for delivery	$500 / admission ($300 for selected hospitals) and no charge for delivery	$1,000 / admission and no charge for delivery	Not covered	——— none ———
If you need help recovering or have other special health needs	Home health care	No charge	No charge	No charge	Not covered	Pre-authorization required
	Rehabilitation services	$45 / visit	$45 / visit	$45 / visit	Not covered	Limited to 60 visits per calendar year (other than for autism, home health care, and speech therapy)
	Habilitation services	$45 / visit	$45 / visit	$45 / visit	Not covered	Rehabilitation therapy coverage limits apply; cost share and coverage limits waived for early intervention services for eligible children
	Skilled nursing care	No charge	No charge	No charge	Not covered	Limited to 100 days per calendar year; pre-authorization required
	Durable medical equipment	No charge	No charge	No charge	Not covered	Limited to $750 per calendar year
	Hospice service	No charge	No charge	No charge	Not covered	Pre-authorization required for certain services
If your child needs dental or eye care	Eye exam	No charge	No charge	No charge	Not covered	Limited to one exam every 24 months
	Glasses	Not covered	Not covered	Not covered	Not covered	——— none ———
	Dental check-up	Not covered	Not covered	Not covered	Not covered	——— none ———

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Children's dental check-up
- Children's glasses
- Cosmetic surgery
- Dental care (adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care
- Hearing aids ($2,000 per ear every 36 months for members age 21 or younger)
- Infertility treatment
- Routine eye care - adult (limited to one exam every 24 months)
- Routine foot care (only for patients with systemic circulatory disease)
- Weight loss programs ($150 per calendar year per policy)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

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Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the Member Service number listed on your ID card or contact your plan sponsor. Note: A plan sponsor is usually the member's employer or organization that provides group health coverage to the member. You may also contact The Office of Patient Protection at 1-800-436-7757 or www.state.ma.us/dph/opp.

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NAVAJO (Dine): Dinek'ehjí shika' a'dowoł ninizingo, kwojí hodiiłné t'áá jííkeh béésh bee' hane'jį T'áá doolé'é bina'íshdiłkidgo yeeháká'adoojah éí binumber bee néého'dolzin biniiyé naanitinígíí bikáá' doo.

Disclaimer:

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To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,040
- **Patient Pays** $500

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient Pays:

Deductibles	$0
Copays	$500
Coinsurance	$0
Limits or exclusions	$0
Total	**$500**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,110
- **Patient Pays** $2,290

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient Pays:

Deductibles	$0
Copays	$1,740
Coinsurance	$0
Limits or exclusions	$550
Total	**$2,290**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: 1-800-262-Blue(2583).

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied to the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from standard benefits tier **providers**. If the patient had received care from other in-network or out-of-network **providers**, costs would have been different.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You also should consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call **1-800-932-8323** or visit us at www.bluecrossma.com.

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MASSACHUSETTS

MCC Compliance

This health plan meets Minimum Creditable Coverage Standards for Massachusetts residents that went into effect as of January 1, 2011, as part of the Massachusetts Health Care Reform Law.

#115106
55-0342 (5/12) 5M

MASSACHUSETTS

Information About the Plan

This health plan includes a tiered provider network called HMO Blue Options v.4. Members in this plan pay different levels of cost share (copayments, coinsurance, and/or deductibles) depending on the benefits tier of the provider furnishing the services. A provider's benefits tier may change. Overall changes to the benefits tiers of providers will happen no more than once each calendar year. For help in finding the benefits tier of a provider, visit the online provider search tool at **www.bluecrossma.com/findadoctor** and search for HMO Blue Options v.4.

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55-0405 (9/12) 2M

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.bluecrossma.com or by calling **1-800-932-8323**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$500** member / **$1,000** family. Does not apply to preventive care, prenatal care, prescription drugs, most office visits, mental health visits	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. **$2,000** member / **$4,000** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Copayments $100 or less, prescription drugs, premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.bluecrossma.com/findadoctor **or call 1-800-821-1388** for a list of network providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** (or provider's charge if it is less than the **allowed amount**) for the service. For example, if the plan's **allowed amount** for an overnight stay is $1,000 (and it is less than the provider's charge), your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts. (If you have elected a Health Savings Account (HSA), you may have access to additional funds to help cover certain **out-of-pocket** expenses such as **copayments**, **coinsurance**, **deductibles** and costs related to services not otherwise covered.)

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		In-Network	Out-of-Network	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 / visit	Not covered	——— none ———
	Specialist visit	$35 / visit	Not covered	——— none ———
	Other practitioner office visit	$35 / chiropractor visit	Not covered	Deductible applies first; limited to 12 visits per calendar year for age 16 and older
	Preventive care/screening/immunization	No charge	Not covered	GYN exam limited to one exam per calendar year
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	Deductible applies first
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	Deductible applies first; pre-authorization required for certain services

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		In-Network	Out-of-Network	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bluecrossma.com.	Generic drugs	$15 / retail or $30 / mail service supply	Not covered	Up to 30-day retail (90-day mail service) supply; cost share waived for birth control; pre-authorization required for certain drugs
	Preferred brand drugs	$30 / retail or $60 / mail service supply	Not covered	Up to 30-day retail (90-day mail service) supply; pre-authorization required for certain drugs
	Non-preferred brand drugs	$50 / retail or $150 / mail service supply	Not covered	Up to 30-day retail (90-day mail service) supply; pre-authorization required for certain drugs
	Specialty drugs	$30 / supply	Not covered	Up to 30-day supply; pre-authorization required for certain drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	Deductible applies first; pre-authorization required for certain services
	Physician/surgeon fees	No charge	Not covered	Deductible applies first; pre-authorization required for certain services
If you need immediate medical attention	Emergency room services	$150 / visit	$150 / visit	——— none ———
	Emergency medical transportation	No charge	No charge	Deductible applies first
	Urgent care	$35 / visit	$35 / visit	Out-of-network coverage limited to out of service area
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	Deductible applies first; pre-authorization required
	Physician/surgeon fee	No charge	Not covered	Deductible applies first; pre-authorization required

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		In-Network	Out-of-Network	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 / visit	Not covered	Pre-authorization required for certain services
	Mental/Behavioral health inpatient services	No charge	Not covered	Deductible applies first; pre-authorization required
	Substance use disorder outpatient services	$20 / visit	Not covered	Pre-authorization required for certain services
	Substance use disorder inpatient services	No charge	Not covered	Deductible applies first; pre-authorization required
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	——— none ———
	Delivery and all inpatient services	No charge	Not covered	Deductible applies first
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Deductible applies first; pre-authorization required
	Rehabilitation services	$35 / visit	Not covered	Deductible applies first; limited to 60 visits per calendar year (other than for autism, home health care, and speech therapy)
	Habilitation services	$35 / visit	Not covered	Deductible applies first; rehabilitation therapy coverage limits apply; cost share and coverage limits waived for early intervention services for eligible children
	Skilled nursing care	No charge	Not covered	Deductible applies first; limited to 100 days per calendar year; pre-authorization required
	Durable medical equipment	No charge	Not covered	Deductible applies first; limited to $750 per calendar year
	Hospice service	No charge	Not covered	Deductible applies first; pre-authorization required for certain services

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		In-Network	Out-of-Network	
If your child needs dental or eye care	Eye exam	No charge	Not covered	Limited to one exam every 24 months
	Glasses	Not covered	Not covered	——— none ———
	Dental check-up	Not covered	Not covered	——— none ———

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Acupuncture	• Cosmetic surgery	• Non-emergency care when traveling outside the U.S.
• Children's dental check-up	• Dental care (adult)	• Private-duty nursing
• Children's glasses	• Long-term care	

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Bariatric surgery	• Infertility treatment	• Weight loss programs ($150 per calendar year per policy)
• Chiropractic care	• Routine eye care - adult (limited to one exam every 24 months)	
• Hearing aids ($2,000 per ear every 36 months for members age 21 or younger)	• Routine foot care (only for patients with systemic circulatory disease)	

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See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,040
- **Patient Pays** $500

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient Pays:

Deductibles	$500
Copays	$0
Coinsurance	$0
Limits or exclusions	$0
Total	**$500**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $2,610
- **Patient Pays** $2,790

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient Pays:

Deductibles	$500
Copays	$1,740
Coinsurance	$0
Limits or exclusions	$550
Total	**$2,790**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: 1-800-262-Blue(2583).

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied to the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

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124531BS (2/13) TBD LS

MASSACHUSETTS

MCC Compliance

This health plan meets Minimum Creditable Coverage Standards for Massachusetts residents that went into effect as of January 1, 2011, as part of the Massachusetts Health Care Reform Law.

#115106
55-0342 (5/12) 5M

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Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,000** member / **$2,000** family. Does not apply to preventive care, prenatal care, prescription drugs, most office visits, mental health visits.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. **$2,000** member / **$4,000** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Copayments $100 or less, prescription drugs, premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.bluecrossma.com/findadoctor **or call 1-800-821-1388** for a list of network providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** (or provider's charge if it is less than the **allowed amount**) for the service. For example, if the plan's **allowed amount** for an overnight stay is $1,000 (and it is less than the provider's charge), your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts. (If you are a group member and are eligible to elect a Health Reimbursement Account (HRA), Flexible Spending Account (FSA) or you have elected a Health Savings Account (HSA), you may have access to additional funds to help cover certain **out-of-pocket** expenses such as **copayments**, **coinsurance**, **deductibles** and costs related to services not otherwise covered.)

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		In-Network	Out-of-Network	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 / visit	Not covered	——— none ———
	Specialist visit	$35 / visit	Not covered	——— none ———
	Other practitioner office visit	$35 / chiropractor visit	Not covered	Deductible applies first; limited to 12 visits per calendar year for age 16 and older
	Preventive care/screening/immunization	No charge	Not covered	GYN exam limited to one exam per calendar year
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	Deductible applies first
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	Deductible applies first; pre-authorization required for certain services

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		In-Network	Out-of-Network	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bluecrossma.com.	Generic drugs	$15 / retail or $30 / mail service supply	Not covered	Up to 30-day retail (90-day mail service) supply; cost share waived for birth control; pre-authorization required for certain drugs
	Preferred brand drugs	$30 / retail or $60 / mail service supply	Not covered	Up to 30-day retail (90-day mail service) supply; pre-authorization required for certain drugs
	Non-preferred brand drugs	$50 / retail or $150 / mail service supply	Not covered	Up to 30-day retail (90-day mail service) supply; pre-authorization required for certain drugs
	Specialty drugs	$30 / supply	Not covered	Up to 30-day supply; pre-authorization required for certain drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	Deductible applies first; pre-authorization required for certain services
	Physician/surgeon fees	No charge	Not covered	Deductible applies first; pre-authorization required for certain services
If you need immediate medical attention	Emergency room services	$150 / visit	$150 / visit	——— none ———
	Emergency medical transportation	No charge	No charge	Deductible applies first
	Urgent care	$35 / visit	$35 / visit	Out-of-network coverage limited to out of service area
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	Deductible applies first; pre-authorization required
	Physician/surgeon fee	No charge	Not covered	Deductible applies first; pre-authorization required
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 / visit	Not covered	Pre-authorization required for certain services
	Mental/Behavioral health inpatient services	No charge	Not covered	Pre-authorization required
	Substance use disorder outpatient services	$20 / visit	Not covered	Pre-authorization required for certain services
	Substance use disorder inpatient services	No charge	Not covered	Pre-authorization required

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		In-Network	Out-of-Network	
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	No charge applies only to prenatal care
	Delivery and all inpatient services	No charge	Not covered	Deductible applies first
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Deductible applies first; pre-authorization required
	Rehabilitation services	$35 / visit	Not covered	Deductible applies first; limited to 60 visits per calendar year (other than for autism, home health care, and speech therapy)
	Habilitation services	$35 / visit	Not covered	Deductible applies first; rehabilitation therapy coverage limits apply; cost share and coverage limits waived for early intervention services for eligible children
	Skilled nursing care	No charge	Not covered	Deductible applies first; limited to 100 days per calendar year; pre-authorization required
	Durable medical equipment	No charge	Not covered	Deductible applies first; limited to $750 per calendar year
	Hospice service	No charge	Not covered	Deductible applies first; pre-authorization required for certain services
If your child needs dental or eye care	Eye exam	No charge	Not covered	Limited to one exam every 24 months
	Glasses	Not covered	Not covered	——— none ———
	Dental check-up	Not covered	Not covered	——— none ———

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Children's dental check-up
- Children's glasses
- Cosmetic surgery
- Dental care (adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care
- Hearing aids ($2,000 per ear every 36 months for members age 21 or younger)
- Infertility treatment
- Routine eye care - adult (limited to one exam every 24 months)
- Routine foot care (only for patients with systemic circulatory disease)
- Weight loss programs ($150 per calendar year per policy)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact your plan sponsor. Note: A plan sponsor is usually the member's employer or organization that provides group health coverage to the member. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the Member Service number listed on your ID card or contact your plan sponsor. Note: A plan sponsor is usually the member's employer or organization that provides group health coverage to the member. You may also contact The Office of Patient Protection at 1-800-436-7757 or www.state.ma.us/dph/opp.

Language Assistance

To obtain language assistance, please call the toll-free Member Service number on your ID card.

SPANISH (Español): Para obtener asistencia en español, llame al número gratuito de Servicio de Atención al Miembro que figura en su tarjeta de identificación.

TAGALOG (Tagalog): Kung kailangan ninyo ng tulong sa Tagalog tumawag sa libreng numero ng telepono ng Serbisyo sa Miyembro na nakasulat sa inyong ID card.

CHINESE (中文): 如果您需要中文語言幫助，請撥打會員卡上的客戶服務免費電話號碼

NAVAJO (Dine): Dinek'ehjí shika' a'dowoł ninizingo, kwojí hodiiłné t'áá jííkeh béésh bee' hane'jį T'áá doolé'é bina'íshdiłkidgo yeeháká'adoojah éí binumber bee néého'dolzin biniiyé naanitinígíí bikáá' doo.

Disclaimer:

This document contains only a partial description of the benefits, limitations, exclusions and other provisions of this health care plan. It is not a policy. It is a general overview only. It does not provide all the details of this coverage, including benefits, exclusions and policy limitations. In the event there are discrepancies between this document and the policy, the terms and conditions of the policy will govern.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,540
- **Patient Pays** $1,000

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient Pays:

Deductibles	$1,000
Copays	$0
Coinsurance	$0
Limits or exclusions	$0
Total	**$1,000**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $2,110
- **Patient Pays** $3,290

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient Pays:

Deductibles	$1,000
Copays	$1,740
Coinsurance	$550
Limits or exclusions	$0
Total	**$3,290**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: 1-800-262-Blue(2583).

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied to the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You also should consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call **1-800-932-8323** or visit us at www.bluecrossma.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.bluecrossma.com/sbcglossary or call **1-800-932-8323** to request a copy.

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MASSACHUSETTS

MCC Compliance

This health plan meets Minimum Creditable Coverage Standards for Massachusetts residents that went into effect as of January 1, 2011, as part of the Massachusetts Health Care Reform Law.

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Doctor and Hospital Tiering for HMO Blue Options

Under the HMO Blue Options v.4 plan, doctors and hospitals are categorized in tiers based on quality and cost. If you choose this network, you will pay different levels of cost (copayments, co-insurance and/or deductibles) depending on the benefits tier of the doctor or hospital providing the service. Doctors are measured for their tiers based on their HMO patients as part of their provider group. Hospitals are measured for their tiers based on their individual facility performance.

The best way to decide if HMO Blue Options is best for you and your family, make a list of all your doctors and hospitals. Each doctor and hospital is ranked in either the Enhanced Benefits Tier, the Standard Benefits Tier or the Basic Benefits Tier.

- **Enhanced Benefits Tier** - Includes Massachusetts doctors and hospitals that met the quality benchmark and benchmark for lowest cost.
- **Standard Benefits Tier** - Includes Massachusetts doctors and hospitals that met the quality benchmark and benchmark for moderate cost.
- **Basic Benefits Tier** - Includes Massachusetts doctors and hospitals that scored below the quality benchmark and benchmark for moderate cost.

Once you identify your doctors, go to Blue Cross Member Central at www.bluecrossma.com. Click on Member, Using My Plan, Doctors and Hospitals and Find a Doctor or Hospital. Go to Select Your Plan Network and choose HMO Blue Options v.4. You will then be able to search for your doctor or hospital. Click on your choice and click Check Provider Tier. This will tell you which tier your doctor and/or hospital falls under.

Listed below is an example of area hospitals and where they rank in the tiers:

Baystate Medical Center, Springfield – Basic Tier

Baystate Mary Lane, Ware – Standard Tier

Baystate Franklin Medical Center, Greenfield – Standard Tier

Berkshire Medical Center, Pittsfield – Basic Tier

Cooley Dickinson Hospital, Northampton – Standard Tier

Holyoke Medical Center, Holyoke – Standard Tier

Mercy Medical Center, Springfield – Enhanced Tier

Noble Hospital, Westfield – Enhanced Tier

Wing Memorial Hospital, Palmer – Enhanced Tier

If you are a Blue Cross Blue Shield member, did you know…

Blue Cross members can access a 24-hour nurse hotline for free

Not sure if you need to make that trip to the Emergency Room? Wouldn't it be nice to have a medical professional available at any time to offer help with questions like these? Now you can, just by picking up the phone and calling the Blue Care Line toll-free at **1-888-247-BLUE (2583)**. With the Blue Care Line, you can speak with a registered nurse 24 hours a day, 7 days a week. And best of all, it's a free service to Blue Cross Blue Shield of Massachusetts members.

You can save money on your prescriptions

If you take prescription drugs for a long term condition (high blood pressure, allergies, etc.), you can save a considerable amount of money by ordering your prescriptions through mail order. For example, a 30 day supply may cost you $10.00 and a 90 day supply may cost you the same! Once you begin mail order, you can conveniently order refills by phone or on line. No more waiting in line at your pharmacy!

All Blue Cross member are entitled to a program called Healthy Blue

This program offers you discounts, resources and tools to help you get the most from your health care plan. There is a fitness benefit which allows you up to $150.00 toward membership at a health or reimbursement of up to $150.00 for a program such as Weight Watchers, Jenny Craig or Nutrisystem. Living Healthy Naturally may provide discounts on alternative medicine such as acupuncture, massage therapy, tai chi and yoga. For more information on these and other programs, call 1-800-262-BLUE.

As a Blue Cross member, you can get special offers through Drugstore.com

Be sure to take advantage of the special offers on health and wellness products available through drugstore.com. As a special introductory offer, when you purchase select heart rate monitor products, you'll get a complimentary sports backpack. In fact, you'll get free shipping for every non-prescription order over $45!

You can purchase pet insurance through Purina

People treat their pets as an extension of their family. Pet health care is not immune to rising costs so when your pet is ill or injured, the cost of that care can be expensive. Your vet bills can be offset and paid for with pet insurance coverage through PurinaCare, a subsidiary of Purina, a trusted name with over 85 years of understanding pets and the people who love them. Visit www. Purinacare.com and enter the code IISPC or call (877) 878-7462 for further information. You'll be glad you did.

Voluntary Life Insurance

Part of your benefits package includes voluntary enrollment in life insurance through The Standard Life Insurance Company, a leader in the group disability and life insurance market.

You are eligible for life insurance coverage if you are an active employee working at least 20 hours per week. The City of Chicopee pays 50% of your life insurance premium. The monthly cost is $8.55 for $20,000 worth of life insurance coverage. Additional life insurance is available in increments of $10,000 to a maximum of $200,000, which the City does not contribute to.

You must enroll in the plan within 30 days of your date of hire. If you wish to purchase life insurance more than 31 days after becoming eligible to apply, you will need to submit a Medical History Statement.

If you become disabled (as defined by the Plan) and are no longer able to work, your premium payments may be waived after a period of 180 days of consecutive total disability.

If your insurance ends because your employment terminates, you have a 31 day period in which to buy portable group insurance coverage up to $300,000. If your insurance ends or is reduced due to a qualifying event, you have a 31 day period in which to buy conversion whole life insurance coverage.

For further information, contact the HR department at (413) 594-1510 or visit the City website at www.chicopeema.gov.

Employee Assistance Program (municipal employees only)

We all face problems from time to time. Usually, we can handle them ourselves without help from outside resources but sometimes it makes more sense to reach out for assistance. That is why we provide our employees and their families with a confidential EAP, a benefit that provides resources and solutions for the problems we encounter. The City of Chicopee has covered the entire cost of this benefit, therefore there is no cost to you.

In addition to counseling benefits, your EAP provides assistance for financial and legal issues. Solutions for your everyday work/life problems include debt restructuring, help finding child or elder care, assistance with real estate and tenant/landlord concerns and help with interpersonal skills with family and co-workers.

Lifestyle benefits with the EAP include discounts and savings plans to help you with nutritional planning, fitness, smoking cessation, weight loss and retirement/college planning. You can also balance your work and life with the help of the EAPs Personal Development Program. Visit their website for tutorials, exercises and worksheets.

To reach the EAP for free, confidential assistance, call (800) 252-4555 or log on to their website at www.theEAP.com.

Frequently Asked Questions

Q. My spouse and I are expecting a child. What do I need to do?

A. You have 30 days from the date of the birth of the baby to enroll him/her. At this time, you are allowed to enroll your spouse. You must fill out an enrollment form and provide a copy of the baby's birth certificate. Coverage is retroactive to the date of the birth of the baby and you will be charged accordingly.

Q. My medical insurance is covered under my spouse's plan through my spouse's employer. My spouse will be losing medical insurance coverage due to a lay off. Can I enroll in our plan?

A. You will have 30 days from the date of the loss to enroll. You must fill out an enrollment form and provide a HIPPA certificate. Coverage is retroactive and you will be charged accordingly.

Q. I will be getting married soon. When can I enroll my new spouse on to our plan?

A. You have 30 days from the date of the marriage to enroll your spouse. You must fill out an enrollment form and include a copy of the marriage certificate. Coverage is retroactive to the date of the marriage and you will be charged accordingly.

Q. I will be separating or getting a divorce soon. What do I need to do?

A. Be sure to notify Human Resources with any change to your personal situation. If your spouse is enrolled on the City's health insurance plan, your legal separation or divorce decree may require you to add and/or drop your spouse from your plan. In order to do this, you will need to send a copy of the agreement, the health insurance provisions agreed to and the "absolute" date which is the date your divorce or legal separation became final.

Q. Can I remove my legally separated or former spouse from my health insurance coverage?

A. By law, the legally separated or former spouse can be removed according to the terms of the divorce agreement. If the former spouse provides proof of other health coverage and does not wish to remain on the City's plan, he/she can be removed from coverage.

Q. What if I remarry? Can I remove my legally separated or former spouse from my health insurance coverage?

A. If you or your former spouses remarry, coverage for the legally separated or former spouse ends, in accordance with state laws. Depending on the language of the divorce decree, the former spouse may be eligible for COBRA coverage.

Q. What is COBRA?

A. The Consolidated Omnibus Budget Reconstruction Act, also known as COBRA, is an extension of health insurance offered to you when you leave your employment. You have the right to choose to continue your health benefits for a limited period of time. Qualified individuals may be required

to pay the entire premium for coverage up to 102 percent of the cost to the plan.

Q. I will be moving to a new address. Is there anything that I need to do?

A. Any change to your personal information may affect your insurance coverage. Please contact Human Resources if any of the following occur: marriage or remarriage, legal separation, divorce, address change, death of a covered spouse or dependent, birth, adoption or legal guardianship of a child. Failure to provide timely notification of a change in personal information may affect your insurance coverage.

Q. What is a deductible?

A. A deductible is a fixed dollar amount you must pay each plan year (July 1 to June 30) before your health plan begins paying benefits to you or your covered dependents. Deductibles vary from plan to plan. Information about your plan can be found at www.chicopeema.gov.

Q. How do I know what health care services are subject to the deductible?

A. Each plan lists the services where a deductible applies. For most routine services like annual checkups, well child visits and immunizations, the deductible does not apply. Examples of expenses generally subject to the deductible may include emergency room visits, inpatient hospitalization, surgery and laboratory and blood tests.

Q. How do I know how much I need to pay out of pocket?

A. Out of pocket expenses vary from plan to plan and generally, out of pocket expenses include your deductible and co-pays. For example, when you visit a doctor or hospital, you pay that co-pay in advance. After you receive services, your health plan will mail you an Explanation of Benefits (EOB) so that you will be able to see which portion of the costs you will be responsible for. The provider will then bill you for any balance owed. You can also contact your health plan provider for information on the balance of your out of pocket expenses.

Q. I am not happy with the plan I chose. When can I change my coverage?

A. The only time you can change your plan is during Open Enrollment with an effective date of July 1. You can also change your coverage if you have a "qualifying event" such as marriage, divorce, birth of a child, loss of other coverage, etc.

Q. I need to have extensive dental work and my dentist told me she is submitting a Pre-Treatment Estimate to Blue Cross. What is a Pre Treatment Estimate?

A. If your dentist expects that your treatment will involve covered services over $250, she should send a copy of your treatment plan to Blue Cross. Once the plan is reviewed, you and your dentist will be notified what will be covered and what, if any, you will have to pay out of pocket. Our plan has a $1,000 calendar year benefit maximum so you need to know how much money will be available to you at the time of treatment. To find out your balance, call Dental Blue at 1-800-932-8323.

Q. I will be turning 65 and I plan to continue working for the City. What do I need to do?

A. At age 65, if you are actively working for the City, you may remain on the City's active health insurance plan.

Q. I am not age 65 but my spouse, who is on my insurance plan, will be turning 65. What should my spouse do?

A. If you are actively working for the City and your spouse turns 65, you and your spouse may remain on the City's health insurance plan.

Q. I will be taking a leave of absence from my job. What happens to my health insurance during my absence?

A. If you take an unpaid leave of absence, you will be required to make arrangements for payment of your health insurance premium through the City of Chicopee's Treasurers office. If you are eligible for leave, such as Family and Medical Leave (FMLA), you will be required to use your available paid sick and/or vacation and/or other leave during your FMLA absence. This earned time can be applied to your health insurance premium.

Information for City of Chicopee Retirees and Survivors

During Open Enrollment or at the time of your retirement, you have four choices of plans to choose from. Blue Cross offers MedEx, HMO Blue Medicare and Blue Cross Managed Blue. Health New England offers Medicare Advantage.

Start by reviewing the benefit summaries for each plan. Weigh the features that are important to you and your family. What are the deductibles? Are there any out of pocket expenses? What about prescription drug coverage? What are the monthly rates?

Once you identify plans you are interested in, determine if your doctors and hospitals are in the plan's network. The best way to research the plans is by accessing the plan websites or by calling them directly.

We have provided you with a condensed benefits overview for each plan. If you have any questions or concerns, please call Blue Cross or Health New England directly for further information.

Blue Cross can be contacted by calling Member Services at 1-800-262-BLUE (2583) or by visiting their website at www.bluecrossma.com.

Health New England (HNE) can be contacted by calling Member Services as 1-413-787-4004 or by visiting their website at www.hne.com.

How do I know if I am eligible to retire?

The Chicopee Contributory Retirement System is a retirement system for eligible employees of the City of Chicopee. This system is regulated under Chapter 32 of the Massachusetts General Laws and overseen by the Public Employee Retirement Administration Commission (PERAC). Information can be obtained from their website at www.mass.gov/perac or by calling (617) 666-4446.

The Retirement Board determines whether you meet eligibility requirements for a City pension. You will be eligible to continue your benefits when you retire, provided you receive a pension from the City.

Members and retirees can contact the Retirement office at (413) 594-1542 or email Executive Director Susana Baltazar at sbaltazar@chicopeema.gov.

The Massachusetts Teachers Retirement System is located at One Charles Place, Cambridge, MA 02142. They can be contacted by telephone at (617) 679-6877 or you can access their website at http://mass.gov/mtrs.

Information for retirees under the age of 65

If you are insured with the City at the time of retirement, you have the following options:

- If you are living in the health insurance service area, you can stay enrolled on the City plan.
- If you move from the health insurance service area, the only option you have for coverage is the Health New England PPO.
- You can change plans during Open Enrollment. The change will be effective July 1. Open Enrollment usually occurs in the Spring each year.

If you are not insured with the City at time of retirement, you have the following options:

- You can enroll on the City plan at time of retirement since this is a qualifying event.
- You can enroll on the City plan if you lose coverage from another plan. This must take place within 30 days of the loss of coverage.
- You can enroll on the City plan during Open Enrollment. The change will be effective July 1. Open Enrollment usually occurs in the Spring.

PLEASE NOTE: If your spouse/dependent is not covered at the time of your death, he/she is not eligible to enroll on the City plan. If your spouse/dependent is covered at the time of your death, he/she can continue on the City plan until death or ineligibility, but if coverage is cancelled at any time, the spouse/dependent is not able to re-enroll on the City plan at any time.

Will you be turning 65 soon?

If so, here's what you need to do. Three months prior to your birthday month, you should contact the Social Security office by calling 866-964-5061. You need to find out if you are eligible for Medicare Part B. You may be eligible through yourself or your spouse. If you are eligible for Medicare Part B, you must accept it. The City of Chicopee has adopted Chapter 32B, Section 18, which requires retirees to participate in Medicare Part B. This section states that the information must be submitted to continue coverage on the City plan.

You need to have the Social Security office complete a Medicare Health Insurance Information form, which you can obtain from the Human Resources office or the City's website at www.chicopeema.gov. This form will need to be completed to prove your status regarding Medicare Part B. Failure to do so may cause you to become ineligible for the City plan.

What is Medicare?

Medicare is a federal health insurance program for retirees age 65 or older and certain disabled people. Medicare Part A covers inpatient hospital care, some skilled nursing facility care and hospice care. If you are eligible, there is no cost for Medicare Part A.

Medicare Part B covers physician care, diagnostic x-rays and lab tests and durable medical equipment. There is a cost associated with Medicare Part B. The premium is set by the Centers for Medicare and Medicaid Services (CMS). You can contact them or your local Social Security office for the current premium cost. If you do not enroll in Medicare Part B within the required time, you may be required to pay federal government penalties.

Medicare Part C is a Medicare Advantage Plan that is offered by private companies approved by Medicare. If you join a Medicare Advantage Plan, the plan will provide all of your Part A (Hospital Insurance) and Part B (Medical Insurance) coverage. Medicare Advantage Plans may offer extra coverage, such as vision, hearing, dental, and/or health and wellness programs. Most include Medicare prescription drug coverage (Part D).

Medicare Part D is a federal prescription program. To get Medicare prescription drug coverage, you can enroll in one of the City's supplemental plans or you can join a plan run by an insurance company or other private company approved by Medicare. Each plan can vary in cost and prescriptions covered.

Medicare only coverage is not recommended as it has coverage limitations. To ensure comprehensive coverage, Retirees should enroll in a supplemental health plan sponsored by the City.

Medicare, Social Security, Part A & B…I'm so confused!

It's time to contact SHINE. The SHINE Program (Serving Health Information Needs of Elders) is a state health insurance assistance program that provides free health insurance information, counseling and assistance to Massachusetts residents with Medicare. The SHINE program ensures that Massachusetts residents with Medicare have access to accurate, unbiased and up-to-date information about their health care options.

A SHINE counselor is a committed volunteer who is trained and certified by the Executive Office of Elder Affairs in many areas of health insurance, including Medicare Part A, Part B, Part D, Medigap insurance, Medicare HMOs, retiree insurance plans, prescription drug programs, Medicaid assistance and other programs. For more information, call the Office of Elder Affairs at (413) 750-2893.

Another excellent resource is the Council on Aging. The COA is designed to assist older adults in the community with education and support by identifying funding sources to fill elder needs. Their goal is to improve community programming for older adults. Jared Krok, Social Services Coordinator, is a SHINE counselor. For more information, you can contact Jared at jkrok@chicopeema.gov or call the Council on Aging at (413) 534-3698.

In addition to SHINE and the Council on Aging, the Public Library on 449 Front Street in Chicopee offers a program called "Turning 65 and Medicare." This informative program is offered free of charge and takes place the first Monday of every month at 6:00 p.m. For more information, call the Chicopee Public Library at (413) 594-1800 or visit the website at www.chicopeepubliclibrary.org.

What coverage do I lose when I retire?

When you retire, you may continue health, dental and retiree life insurance coverage. You also have the option to change your health insurance plan. For more information, please contact Human Resources at (413) 594-1510.

If you are enrolled in vision insurance, you will lose your coverage when you retire. You may continue vision coverage for up to 18 months through COBRA. For more information, please contact Human Resources at (413) 594-1510.

If you are enrolled in life insurance, your policy will automatically be converted to a basic life policy of $3,000. The premium for this coverage will automatically be deducted from your pension check.

If you are enrolled in the Flexible Spending Account (FSA) at the time of your retirement, your contributions will end with your last paycheck. You can submit claims for qualified expenses incurred before or after your termination date, as long as you still have funds left in your account and it is within the regular plan year or grace period. Once the funds have been exhausted or the plan year/grace period ends, the FSA will be discontinued.

Retiree Frequently Asked Questions / What if…

Q. My spouse is 65 and on my retiree insurance plan. What should my spouse do?

A. Before turning 65, your spouse should call or visit your local Social Security office for confirmation of Social Security and Medicare benefit eligibility. If your spouse is eligible for Parts A & B, he/she will be eligible to enroll in one of the City's supplemental plans. If your spouse is ineligible for Parts A & B, he/she will be eligible to remain on your current plan.

Q. My spouse is not covered at the time of my death. Can he/she enroll on the City's plan?

A. At the time of your death, if your spouse in not on your plan, he/she cannot enroll on the City's plan. If your spouse is covered at the time of your death, he/she can continue on the City plan until death or ineligibility. If coverage is cancelled at any time, the spouse is not able to re-enroll on the city plan.

Q. In my career, I have never contributed into the Social Security system. Why do I need to know about Medicare?

A. You may still be eligible for Medicare benefits. For example, if you are married, you may be eligible for Medicare through your spouse. When you turn age 65, call or visit your local Social Security office for eligibility information.

Q. I'm moving. What do I need to do?

A. Any change to your personal information may affect your insurance coverage. Please contact Human Resources if you have a significant change such as marriage, legal separation, divorce, address change, etc. Failure to provide timely notification of a change in personal information my affect your insurance coverage.

Q. I die, there is no surviving spouse and my minor children are on my insurance plan?

A. Upon your death, your minor children may continue group health insurance coverage until age 26.

Q. I am divorced or legally separated and I die. Is my former spouse eligible for health insurance?

A. No. Your legally separated or former spouse my continue coverage under COBRA. He/she may also apply, if a Massachusetts resident, for health insurance through the Massachusetts Health Connector. They can be reached at (877) 623-6765.

Q. I am the surviving spouse of a Retiree who is covered under my spouse's health insurance. When does my coverage end?

A. Survivor health insurance coverage ends when you stop premium payments, remarry or die. If you remarry, your coverage will end at the end of the month in which you remarry. You are also eligible to continue coverage under COBRA. If you are a Massachusetts resident, you may also purchase health insurance through the

Massachusetts Health Connector. They can be reached at (877) 623-6765.

Q. I am a City employee who has never contributed to Social Security. Do I need to know anything about Medicare?

A. You may still be eligible for Medicare benefits. For example, if you are married, you may be eligible for Medicare through your spouse. When you turn 65, visit your local Social Security office for eligibility information. If you are not eligible for Medicare and you are enrolled in the City's health insurance plan, the City requires you provide proof of denial that you are not eligible. If you can prove you are not eligible for Medicare, you can remain on the City's active health insurance plan.

Q. I only enroll in Medicare and do not participate in the City's plan?

A. Medicare only coverage is not recommended as it has coverage limitations. To ensure you have comprehensive coverage, retirees should enroll in a Medicare health plan sponsored by the City.

Q. I am 65 and actively working. What are my options?

A. If you are actively working, you may remain on the City's active plan. Medicare Part A & B are not required to remain on the City's plan.

Retiree Rates Effective July 1, 2013: Health Insurance

Blue Cross Blue Shield Medex		
	Total Premium	**Monthly Cost**
Single	$401.79	$200.90
Double	$803.58	$401.79

Health New England Medicare Advantage*		
	Total Premium	**Monthly Cost**
Single	$196.90	$98.45
Double	$393.80	$196.90

Blue Cross Blue Shield Managed Blue		
	Total Premium	**Monthly Cost**
Single	$387.82	$193.91
Double	$ 775.64	$387.82

Blue Cross Blue Shield HMO Medicare*		
	Total Premium	**Monthly Cost**
Single	$295.02	$147.51
Double	$ 590.04	$295.02

*rates expected to increase January 1, 2014

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Medex

Medex® 3 Plan 2012–Summary of Benefits

This Medex plan provides benefits for the:

- Medicare Part A Deductible and Co-insurances
- Medicare Part B Deductible and Co-insurance
- Prescription Drugs
- OBRA Benefits

City of Chicopee

This health plan, alone, does not meet Minimum Creditable Coverage standards and will not satisfy the individual mandate that you have health insurance; however, the Commonwealth of Massachusetts has stated that enrollment in Original Medicare (Medicare Part A and Medicare Part B) satisfies these standards.

Your Medical Benefits

	Medicare Provides	Medex Provides
Inpatient Care		
Hospital care—including surgical services, X-rays and laboratory tests, anesthesia, drugs and medications, and intensive care services	• Coverage for days 1–60 per benefit period after $1,156 inpatient deductible • Coverage for days 61–90 after $289 daily co-insurance • Coverage for an additional 60 lifetime reserve days after $578 daily co-insurance	After a $50 inpatient calendar-quarter copayment: • Full coverage of Medicare deductible and co-insurance • Full coverage of lifetime reserve day co-insurance • Full coverage up to 365 additional hospital days in your lifetime when Medicare benefits are used up*
Physician or other professional provider services	80% of approved charges after $140 annual Part B deductible	Full coverage of Medicare deductible and co-insurance
Skilled nursing facility—participating with Medicare**	• Full coverage for days 1–20 • Coverage for days 21–100 after daily $144.50 co-insurance	• Full coverage of Medicare daily co-insurance for days 21–100 • $16 daily for days 101–365
Skilled nursing facility—not participating with Medicare**	No benefits	$16 daily for 365 days per benefit period
Outpatient Care		
Office visits	80% of approved charges after $140 annual Part B deductible	Full coverage after member pays $35 calendar-year deductible
Emergency room visits for accident treatment, sudden and serious medical emergency treatment	80% of approved charges after $140 annual Part B deductible	Full coverage after member pays $25 per visit (waived if admitted or for observation stay)
Outpatient surgery, X-rays and lab tests	80% of approved charges after $140 annual Part B deductible	Full coverage of Medicare deductible and co-insurance
Radiation therapy, durable medical equipment, cardiac rehabilitation services, home health care services, and hospice services	80% of approved charges after $140 annual Part B deductible	Full coverage after member pays $35 calendar-year deductible
Blood glucose monitors and materials to test for the presence of blood sugar	80% of approved charges after $140 annual Part B deductible for all diabetics	Full coverage of Medicare deductible and co-insurance
Urine test strips (Claims must be submitted on a Medex Subscriber Claim form.)	No benefits	Covered to the same extent as brand-name prescription drugs
Chiropractor services	80% of approved charges after $140 annual Part B deductible, for manual manipulation of the spine to correct a subluxation demonstrated by an X-ray	Full coverage after member pays $35 calendar-year deductible
Short-term rehabilitation		
Physical therapy, speech-pathology, and occupational therapy		
Professional provider outpatient services approved by Medicare	80% of approved charges after $140 annual Part B deductible	Full coverage after member pays $35 calendar-year deductible

Your Medical Benefits

	Medicare Provides	Medex Provides
Mental Health and Substance Abuse Treatment		
Biologically based mental conditions†		
Inpatient admissions in a general or mental hospital	• Coverage for days 1–60 per benefit period after $1,156 inpatient deductible • Coverage for days 61–90 after $289 daily co-insurance • Coverage for an additional 60 lifetime reserve days after $578 daily co-insurance • Coverage for mental hospital admissions is limited to 190 days per lifetime	After a $50 inpatient calendar-quarter copayment††: • Full coverage of Medicare deductible and co-insurance • Full coverage of lifetime reserve day co-insurance • Full coverage up to 365 additional hospital days in your lifetime, when Medicare benefits are used up*
Outpatient visits	Full coverage after $140 annual Part B deductible and the Part B co-insurance	• When covered by Medicare, full coverage of Medicare Part B deductible and co-insurance with no visit maximum • When visits are not covered by Medicare, full coverage with no visit maximum
Non-biologically based mental conditions		
Inpatient admissions in a general hospital	• Coverage for days 1–60 per benefit period after $1,156 inpatient deductible • Coverage for days 61–90 after $289 daily co-insurance • Coverage for an additional 60 lifetime reserve days after $578 daily co-insurance	After a $50 inpatient calendar-quarter copayment: • Full coverage of Medicare deductible and co-insurance • Full coverage of lifetime reserve day co-insurance • Full coverage up to 365 additional hospital days in your lifetime, when Medicare benefits are used up*
Inpatient admissions in a mental hospital	Same coverage as a general hospital, but coverage is limited to 190 days per lifetime	• Full coverage of Medicare deductible and co-insurance • Full coverage of lifetime reserve day co-insurance • When Medicare benefits are used up, full coverage up to 120 days per benefit period (at least 60 days per calendar year), less any days in a mental hospital already covered by Medicare or Medex in that benefit period (or calendar year)*
Outpatient visits	Full coverage after $140 annual Part B deductible and the Part B co-insurance	• When covered by Medicare, full coverage of Medicare Part B deductible and co-insurance with no visit maximum • When not covered by Medicare, full coverage up to 24 visits per calendar year

* The additional days are a combination of days in a general or mental hospital.

** A combined maximum of 365 days per benefit period in a Medicare participating and non-participating skilled nursing facility.

† Treatment of rape-related mental or emotional disorders for victims of a rape or victims of an assault with intent to rape is covered to the same extent as biologically based conditions.

† † The inpatient calendar-quarter copayment does not apply to admissions in a mental hospital.

	Medicare Benefits	Medex Provides
Prescription Drugs		
At a designated retail pharmacy	Medicare does not provide coverage for prescription drugs used outside of the hospital. See your Medicare handbook for certain covered drugs.	Full coverage after a: • $10 copayment for Tier 1 • $25 copayment for Tier 2 • $35 copayment for Tier 3
Through the designated mail-service pharmacy (up to a 90-day supply for each prescription or refill)	No benefits	Full coverage after a: • $10 copayment for Tier 1 • $25 copayment for Tier 2 • $35 copayment for Tier 3

Preventive Services Approved by Medicare and Medex

- One routine fecal-occult blood test every year for members age 50 or older (Full coverage for tests)
- One routine flexible sigmoidoscopy every four years for members age 50 or older (Full coverage for tests)
- One routine colonoscopy every two years for a high-risk member (Full coverage for tests)
- Other routine colorectal cancer screening tests or procedures and changes to tests or procedures according to frequency limits set by Medicare (Full coverage for tests)
- Routine prostate cancer screening for members 50 or older including one (PSA) test and one digital rectal exam, per calendar year (Full coverage for exam if doctor accepts assignment, full coverage for PSA test)
- One routine gynecological exam every two years (Full coverage for exam if doctor accepts assignment)
- One routine gynecological exam per calendar year for a member at high risk for cancer (Full coverage for exam if doctor accepts assignment)
- One baseline mammogram during the five year period a member is age 35-39 and one routine mammogram per calendar year for members age 40 and older (Full coverage for screening)
- One routine Pap smear test per calendar year (Full coverage for test)

Important Information

- Blue Cross Blue Shield and Medicare will pay only for services that are medically necessary.
- The Medicare inpatient deductible and co-insurance amounts are subject to change January 1 of each year. The deductibles and co-insurance amounts listed here are for the year 2012.
- Benefits are available immediately upon your effective date.
- You are encouraged to use an Express Scripts pharmacy outside of Massachusetts. These pharmacies will file claims for you as long as you have your ID card with you.

Questions? Call 1-800-932-8323. (TTY) 1-800-522-1254.

The Member Service staff can assist you Monday through Friday, 8 a.m. to 6 p.m.

Medicare Office Telephone Number in Massachusetts: **1-800-MEDICARE (1-800-633-4227)**

For more information about Blue Cross Blue Shield of Massachusetts, log on to: **www.bluecrossma.com**.

Interested in receiving information from Blue Cross Blue Shield of Massachusetts via e-mail? Go to **www.bluecrossma.com/email** to sign up.

Limitations and Exclusions. These pages summarize the benefits of your health care plan. Your plan description and riders define the full terms and conditions. Should any questions arise concerning benefits, the plan description and riders will govern. For a complete list of limitations and exclusions, refer to your plan description and riders.

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Medicare | HMO Blue℠ (HMO)

Benefits Overview 2013

Drug Copayments
$10–$25–$45

Medicare HMO Blue (HMO) is a Medicare Advantage plan from Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association.

Covered Services for Medicare HMO Blue (HMO) Members

Plan Specifics	In-Network
Calendar-Year Deductible	Not applicable
Out-of-Pocket Maximum	$3,400 calendar-year, out-of-pocket maximum (excludes prescription drug cost-sharing)
Covered Services	**Your Cost for In-Network Services**
Doctor's Office Visits	$15 per primary care provider (PCP) visit $30 per specialty care visit
Inpatient Hospital Care Hospital care for illness or chronic disease for as many days as medically necessary (includes hospital care in a rehabilitation hospital)[1]	$150 per day—days 1-5 ($750 annual maximum)
Emergency Care[1] Hospital emergency room visits	$65 per visit, waived if admitted within 24 hours
Urgently Needed Care[1] Doctor's office visit	$15 per PCP visit $30 per other provider visit
Skilled Nursing Facility (SNF) Care Medically necessary care up to 100 days per benefit period[2]	$50 per day—days 1-20 $100 per day—days 21-44 $0 per day—days 45-100
Mental Health and Substance Abuse Outpatient mental health and substance abuse care when medically necessary	$30 per visit
Inpatient care for mental health and substance abuse	$150 per day—days 1-5 ($750 annual maximum)

1. Emergency and Urgently needed care are available worldwide.
2. A benefit period begins with the first day of a Medicare-covered inpatient hospital stay and ends with the close of a period of 60 consecutive days during which you were not an inpatient of a hospital or a skilled nursing facility.

Covered Services for Medicare HMO Blue (HMO) Members

Covered Services	Your Cost for In-Network Services
Medicare-covered Preventive Care and Screening Tests	
Periodic checkups	$0
Mammography screening every 12 months	$0
Routine gynecological exam once per calendar year	$0
Prostate cancer screening exam once per year	$0
Routine Dental Services	
Routine dental care limited to one initial and periodic oral exam, one cleaning, and one set of bite-wing X-rays every 6 months	$30 per visit
Hearing Services	
Routine diagnostic hearing exam once every 12 months	$15 per PCP visit $30 per other provider visit
Hearing aid, batteries, fittings, evaluations, and repairs up to $400 every 36 months	All costs over $400
Vision Care	
Routine refractive eye exam once every 12 months	$30 per visit at a Davis Vision network provider
Eyewear every 24 months up to a $150 maximum	All costs over $150
Other Medicare-Covered Health Services	
Home health services (non-custodial)	$0
Durable medical equipment	0% to 10% of the cost (no cost for diabetes equipment and supplies)
Prosthetic devices and ostomy supplies	0% to 10% of the cost (no cost for diabetes equipment and supplies)
Outpatient diagnostic tests and X-rays	$0 cost for lab tests, X-rays and other diagnostic tests; $100 per day for CT scans, MRIs, PET scans, and nuclear cardiac imaging tests (imaging costs are waived when performed on the same day as an emergency visit or outpatient day surgery)
Outpatient radiation therapy	$0

Covered Services for Medicare HMO Blue (HMO) Members

Covered Services	Your Cost for In-Network Services
Outpatient surgery	$150 per visit
Physical, occupational, and speech therapy	$15 per visit
Podiatry Services Medicare-covered services	 $15 per PCP visit $30 per other provider visit
Chiropractic Services Manual manipulation of the spine to correct subluxation	 $20 per visit
Health and Wellness Programs Disease-specific health and wellness education	 $0
Smoking cessation counseling	$0
Health Promotion Programs Eligible health club membership or exercise classes (up to $150 maximum each calendar year)	 You pay any balance in excess of the $150 limit
Eligible weight loss program (up to $150 maximum each calendar year)	You pay any balance in excess of the $150 limit
Prescription Drug Coverage[3, 4] At a participating retail pharmacy (up to a 30-day supply)[4]	 $10 for generic drugs $25 for preferred drugs $45 for non-preferred drugs
Through a participating mail service pharmacy (up to a 90-day supply)	$20 for generic drugs $50 for preferred drugs $90 for non-preferred drugs

3. Prescription drug copayments apply until your out-of-pocket prescription drug costs for covered Part D drugs reach $4,750; thereafter, you will pay $2.65 for generics or drugs treated like generics, $6.60 for all other drugs, or 5% of the prescription cost, whichever is greater.

   In 2013, members who are not receiving "Extra Help" qualify for the Medicare Coverage Gap Discount Program. After your total yearly drug costs reach $2,970, you receive limited coverage by the plan on certain drugs. You will also receive a discount on drugs and generally pay no more than 47.5% for the plan's costs for brand drugs and 79% of the plan's costs for generic drugs until your yearly out-of-pocket drug costs reach $4,750. Cost sharing adjustments will be applied automatically at the point of sale for qualified members.
4. Prescription drugs may be available at retail pharmacies up to a 90-day supply. If available, calculate the copayment charge for each 30-day supply. Refer to the Evidence of Coverage for more details.

Member Eligibility

To enroll in the plan, retirees must permanently reside in the plan service area and be entitled to Medicare Part A and enrolled in Medicare Part B. In most cases, people with end-stage renal disease (ESRD) cannot enroll in the plan.

To locate a participating network provider:

- Call the Member Service phone line during regular business hours, or
- Call **1-800-810-BLUE (2583)** to find a Blue Medicare Advantage HMO provider, or
- Visit the Doctor and Hospital Finder at **www.bcbs.com** to find a Blue Medicare Advantage HMO provider.

These pages summarize benefits under the Medicare HMO Blue (HMO) plan. Some services may require prior authorization. The benefit information provided herein is a brief summary, not a comprehensive description of benefits. For more information contact the plan.

For More Information

Current members: please call 1-800-200-4255 (TTY: 1-800-522-1254)
Monday–Friday, 8:00 a.m. to 8:00 p.m. ET

Prospective members: please call your employer

Visit www.bluecrossma.com/medicare
or contact your benefits administrator.

Blue Cross Blue Shield of Massachusetts is a Medicare Advantage organization with a Medicare contract.

The benefit information provided is a brief summary, not a complete description of benefits. For more information contact the plan. Limitations, copayments, and restrictions may apply.

Benefits, formulary, pharmacy network, premium and/or copayments/co-insurance may change on January 1 of each year.

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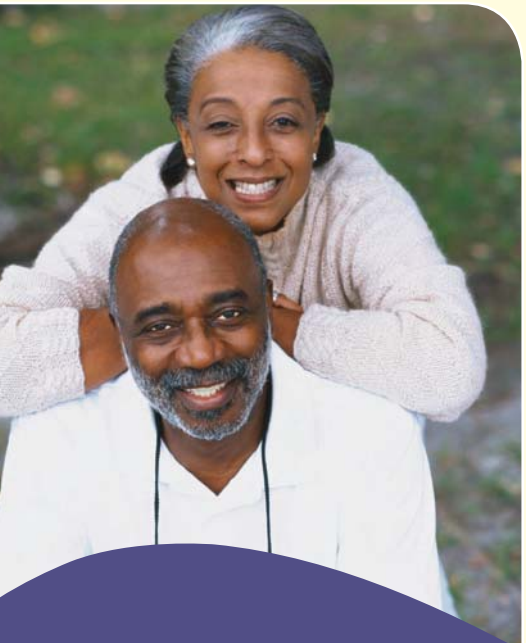
PLAN OVERVIEW

HNE Medicare Advantage Premium (HMO)
Large Employer Group Solution
Calendar Year 2010



Plan Overview Chart

HNE MEDICARE SECURE (HMO)

Employer Group Waiver Plan

Calendar Year 2013

Benefit	HNE Medicare Secure (HMO)
MEDICAL	
Out-of-Pocket Maximum	$3,400
Office Visits ($0 annual preventive exam)	$15
Specialist Office Visits	$15
Inpatient Hospital (3 copayment maximum)	$300 per admission
Outpatient Surgery	$150 *
Skilled Nursing Facility (SNF) (per day)	Days 1-5: $0 copay *; Days 6-50: $75 copay Days 51-100: $0 copay
World Wide Emergency Room (ER)	$65
Ambulance	$75 *
Outpatient Rehabilitation	$15
High Cost Imaging	$50 *
Durable Medical Equipment/Prosthetics	$0 *
ADDITIONAL BENEFITS	
Preventive Hearing Exam+	$15
Preventive Vision Exam+	$0
Vision Eye Wear Allowance+	$100 every two years
Dental Services Allowance+	$150 per year
Fitness/Weight Watchers®/Safety Allowance+	$150 per year
Wig Allowance (if on chemotherapy)	$350 per year
Prescription Drugs - Listed as Generic, Brand and Brand Non-Preferred	Retail $10/$25/$45 Mail Order $20/$50/$135

* Some services require prior authorization. Our network providers know what we cover under your benefit plan. They also know what requires prior authorization and will request approval from HNE on your behalf.

\+ HNE additional benefits include allowances that must be used within the one or two calendar year period, as well as other additional benefits including compression stockings. Refer to the Summary of Benefits or call Member Services if you have questions about what items and services are covered.

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Managed Blue for Seniors℠

Copay Prescription Drug Coverage

Summary of Benefits

This health plan, alone, does not meet Minimum Creditable Coverage standards and will not satisfy the individual mandate that you have health insurance; however, the Commonwealth of Massachusetts has stated that enrollment in Original Medicare (Medicare Part A and Medicare Part B) satisfies these standards.

Your Care

With Managed Blue for Seniors, you have the convenience of selecting a doctor who is close to your home. Your primary care physician attends to all of your health care needs, including hospital services and referrals to specialists.

And we make health care easy. With Managed Blue for Seniors, there are no forms to fill out and no waiting for insurance checks. In most cases, you're covered either in full or with just a **$10** copayment.

When You Travel, You're Covered.

As a member of Managed Blue for Seniors, you'll receive a Blue Cross and Blue Shield ID card. It's one of the most recognized health care cards anywhere. So, if you have a medical emergency away from home, you won't have to worry about an out-of-town hospital not recognizing your coverage. You're covered for an emergency room visit and one medically necessary follow-up visit with a copayment for each. If you're admitted to the hospital, your copayments will be waived, and you'll be covered in full.

Your Medical Benefits

Covered Services	Your Cost
Outpatient Care Routine office visits	$10 per visit
Annual vision examinations	$10 per visit
Allergy care and testing	$10 per visit
Cardiac rehabilitation services	$10 per visit
Chiropractic services	$10 per visit
Immunizations and injections	Nothing
Diagnostic testing	Nothing
X-rays and lab tests	Nothing
Limited oral surgery	$10 per visit
(If you visit a specialist, you will need a referral from your primary care physician in order to receive full benefits. Otherwise your coverage will be limited to Medicare benefits only.)	
Inpatient Care Semiprivate room and board	Nothing
Physician care	Nothing
Surgical services	Nothing
Medications	Nothing
Emergency Room Services (Within the Service Area) Emergency room services for an unforeseen illness or injury. (Copayment is waived if you are admitted to hospital.)	$50 per visit
Emergency Room Services (Outside the Service Area) Emergency room services for an unforeseen illness or injury. One medically necessary follow-up visit is also available (copayment applies). (You must notify the Plan within 48 hours; copayment is waived if you are admitted to hospital.)	$50 per visit

Your Medical Benefits (continued)

Covered Services	Your Cost
Mental Health and Substance Abuse*	
Biologically Based Mental Conditions**	
• Inpatient admissions in a network General or Mental Hospital	Nothing
• Outpatient visits (No limit)	$10 per visit
Non-Biologically Based Mental Conditions	
• Inpatient admissions in a network General Hospital	Nothing
• Inpatient admissions in a network Mental Hospital or Substance Abuse Facility (after Medicare days end, up to 60 days per calendar year)	Nothing
• Outpatient visits covered by Medicare and up to 24 visits per calendar year	$10 copayment
Prescription Drug Program†	
Retail Prescription Drugs	
Generic drugs (up to 30-day supply)	$8 copayment
Brand-name drugs (up to a 30-day supply)	$15 copayment
Mail Service Prescription Drugs	
Generic drugs (up to a 90-day supply)	$10 copayment
Brand-name drugs (up to a 90-day supply)	$20 copayment
Additional Benefits	
Medicare-approved yearly wellness examinations	Nothing
Medicare-approved yearly gynecological examinations	Nothing
Medicare-approved ambulance service when medically necessary per one-way transport (copayment waived for emergency transport)	$40 copayment
Skilled nursing facility (100 days per benefit period)	Nothing
Rehabilitation hospital (365 days in a lifetime, after Medicare days end)	Nothing
Medicare-approved home health care as requested by a Managed Blue for Seniors physician	Nothing
Medicare-approved outpatient physical, speech/language pathology, and occupational therapy (hospital setting)	$10 per visit
Medicare-approved outpatient physical and speech/language pathology (professional providers)	$10 per visit
Medicare-approved outpatient occupational therapy (professional providers)	$10 per visit
Medicare-approved durable medical equipment	$10 per item

* You must call **1-800-524-4010** for referrals.

** Treatment of rape-related mental or emotional disorders for victims of an assault with intent to rape is covered to the same extent as biologically based conditions.

† Prescriptions must be filled through participating pharmacies or participating mail-service providers.

Medicare Covered Preventative Services

Medicare provides coverage for certain preventive services at no cost to members, for example, flu shots, mammography, Pap test, and PSA tests. For the current list of covered preventive services, please refer to your Medicare & You handbook or go to www.medicare.gov.

Get the Most from Your Plan.

Visit us at www.bluecrossma.com/membercentral or call **1-800-262-BLUE (2583)** to learn about discounts, savings, resources, and special programs like those listed below that are available to you.

A Fitness Benefit toward membership at a health club (see your plan description for details)	$150 per year, per individual
Reimbursement for a Blue Cross Blue Shield of Massachusetts designated weight loss program	$150 per year, per individual
Blue Care Line℠—A 24-hour nurse line to answer your health care questions—call 1-888-247-BLUE (2583)	No charge

Questions?

Call **1-800-262-BLUE (2583)**.

For questions about Blue Cross Blue Shield of Massachusetts, visit the website at **www.bluecrossma.com**.

Interested in receiving information from Blue Cross Blue Shield of Massachusetts via e-mail?
Go to www.bluecrossma.com/email to sign up.

Limitations and Exclusions.

Services not covered include cosmetic surgery, custodial care, experimental procedures, pain clinics, personal comfort items and services, and most dental care, unless otherwise outlined. These pages summarize your health care plan. Your plan description and riders define the full terms and conditions. Should any questions arise concerning benefits, the plan description and riders will govern. For a complete list of limitations and exclusions, refer to your plan description and riders.

109603B 35-0290 (11/10)

MASSACHUSETTS

MASSACHUSETTS

Medicare | HMO Blue® (HMO)

To Complete Your Group Enrollment Form:

Be sure to complete all information, sign, and date your enrollment form. Return the completed form(s) to your employer. We will contact you in writing when we receive your enrollment form, and then again to notify you of your effective date of coverage.

To Enroll in Medicare HMO Blue, Please Provide the Following Information:

Last Name: First Name: Middle Initial: Mr. Mrs. Ms.

Birth Date: (/ /) (MM/DD/YYYY) Sex: M F Home Phone Number: ( ) - Alternate Phone Number: ( ) -

Permanent Residence Address (P.O. Box is not allowed):
Number and Street: _____
City: _____ State: _____ Zip: _____

Mailing Address (only if different from your permanent residence address):
Number and Street: _____
City: _____ State: _____ Zip: _____

Emergency Contact Name: _____
Phone Number: _____ Relationship to You: _____

Please Provide Your Medicare Insurance Information

Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white, and blue Medicare card;

– OR –

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

SAMPLE ONLY

Name: _____

Medicare Claim Number
__ __ __ - __ __ - __ __ __ __

Sex _____

Effective Date

Is Entitled To
HOSPITAL (Part A) _____
MEDICAL (Part B) _____

Employer Use Only:
Group Name: _____ Group Number: _____
Requested Effective Date: _____

Office Use Only:
ICEP/IEP: _____ AEP: _____ SEP (type): _____

Please Read and Answer These Important Questions

1. Do you have End Stage Renal Disease (ESRD)? ❑ Yes ❑ No
   If you answered "yes" to this question and you don't need regular dialysis anymore, or if you have had a successful kidney transplant and/or you don't need regular dialysis anymore, please attach a note or records from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

2. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or state pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to Medicare HMO Blue? ❑ Yes ❑ No

If "yes," please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage: _____ ID # for this coverage: _____ Group # for this coverage: _____

3. Do you, either on your own or through your spouse, have any health coverage other than Medicare, such as private insurance, workers compensation, or VA benefits? ❑ Yes ❑ No

What kind of coverage? _____ Name of your insurance company: _____

4. Are you a resident in a long-term care facility, such as a nursing home? ❑ Yes ❑ No

If "yes" please provide the following information:

Name & Address of Institution: _____

Phone Number of Institution: _____

5. Are you enrolled in your State Medicaid program? ❑ Yes ❑ No

If yes, please provide your Medicaid Number: _____

6. Do you or your spouse work? ❑ Yes ❑ No

Please choose the name of a Primary Care Provider (PCP):

Please list your PCP's ID number: _____ Are you a current patient? ❑ Yes ❑ No

Please Read and Sign Below:

By completing this enrollment application, I agree to the following:

Medicare HMO Blue is a Medicare Advantage plan and has a contract with the federal government. I will need to keep my Medicare Parts A and B. I can only be in one Medicare Advantage Plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. Enrollment in this plan is generally for the entire year. I may leave this plan or make changes only at certain times of the year, or under certain special circumstances, by sending a request to Medicare HMO Blue or by calling **1-800-MEDICARE.** TTY users should call **1-877-486-2048.**

Medicare HMO Blue serves a specific service area. If I move out of the area that Medicare HMO Blue serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Medicare HMO Blue, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage from Medicare HMO Blue when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare beneficiaries aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date Medicare HMO Blue coverage begins, I must get all of my health care from Medicare HMO Blue, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Medicare HMO Blue and other services contained in my Medicare HMO Blue Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR MEDICARE HMO BLUE WILL PAY FOR THE SERVICES.**

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that my Medicare HMO Blue plan will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that:

1) this person is authorized under State law to complete this enrollment and

2) documentation of this authority is available upon request from Medicare.

Your Signature: Today's Date:

If you are the authorized representative, you must sign above and provide the following information:

Name: _____

Address: _____

Phone Number: (_____) _____ - _____ Relationship to Enrollee: _____

MASSACHUSETTS

#107742M 37-1020 (9/11) 20M

HNE Medicare Advantage

One Monarch Place · Suite 1500
Springfield, MA 01144-1500
1-413-787-0010 · 1-877-443-3314
TTY/TDD 1-800-439-2370

EMPLOYER GROUP WAIVER PLAN
ENROLLMENT REQUEST FORM

Please contact HNE Medicare Advantage Employer Group Waiver Plan if you need information in another language or format.

To Enroll in an HNE Medicare Advantage Employer Group Waiver Plan, Please Provide the Following Information

Employer Name:		Group #:	
LAST Name:	FIRST Name:	Middle Initial	❒ Mr. ❒ Mrs. ❒ Ms.
Birth Date: (____ / ____ / _____) (M M / D D / Y Y Y Y	Sex: ❒ M ❒ F	Home Phone Number: ( )	Alternate Phone Number: ( )
Permanent Residence Street Address (P.O. Box is not allowed.):			
City:	State:	ZIP Code:	
Mailing Address *(only if different from your Permanent Residence Address):*			
Street Address:	City:	State:	ZIP Code:
E-mail Address:			

Please Provide Your Medicare Insurance Information

Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card

- OR -

- Attach a copy of your Medicare card or your letter from the Social Security Administration or the Railroad Retirement Board.

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

MEDICARE HEALTH INSURANCE

SAMPLE ONLY

Name: _____

Medicare Claim Number Sex_____

__ __ __ - __ __ - __ __ __ __ __

Is Entitled To	Effective Date
HOSPITAL (Part A)	_____
MEDICAL (Part B)	_____

Please read and answer these important questions:

1. Are you the retiree? ❒ Yes ❒ No
   If yes, retirement date: (month/date/year):_____
   If no, name of retiree: _____

2. Are you covering a spouse or dependents under this employer? ❒ Yes ❒ No
   If yes, name of spouse: _____
   Name of dependents: _____

3. Do you or your spouse work? ❒ Yes ❒ No

4. Do you have End Stage Renal Disease (ESRD)? ❒ Yes ❒ No
   If you have had a successful kidney transplant and/or you don't need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

5. Some individuals may have other drug coverage, including other private insurance, Worker's Compenstion VA benefits, or State pharmaceutical assistance programs.

   Will you have other <u>prescription</u> drug coverage in addition to an HNE Medicare Employer Group Waiver Plan?
   ❒ Yes ❒ No
   If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:
   Name of other coverage: ID # for this coverage:

   _____

6. Are you a resident in a long-term care facility, such as a nursing home? ❒ Yes ❒ No
   If "yes" please provide the following information:
   Name of Institution: Address & Phone Number of Institution (number and street):

   _____

Please choose the name of a Primary Care Physician (PCP):_____

PCP Provider ID # (Found in the Provider Directory): _____

Please contact HNE Medicare Advantage Employer Group Waiver Plan at 413-787-0010 or 877-443-3314 (TTY users should call TTY/TDD 1-800-439-2370) if you need information in another format or language. Our office hours are 9 a.m. - 5 p.m., Monday through Friday.

Please Read and Sign Below

<u>By completing this enrollment application, I agree to the following:</u>

HNE Medicare Advantage Employer Group Waiver Plan is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year or under certain special circumstances. Please contact your employer's benefit administrator for more information on times you can enroll.

HNE Medicare Advantage Employer Group Waiver Plan serves a specific service area. If I move out of the area that HNE Medicare Advantage Employer Group Waiver Plan serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of an HNE Medicare Advantage Employer Group Waiver Plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from HNE Medicare Advantage Employer Group Waiver Plan when I get it to know which rules I must follow in order to get coverage with this Medicare Advantage Employer Group Waiver Plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date the HNE Medicare Advantage Employer Group Waiver Plan coverage begins, I must get all of my health care from the HNE Medicare Advantage Employer Group Waiver Plan, except for emergency or urgently needed services or out-of-area dialysis services. Members enrolled in our HNE Medicare Basic (HMO), HNE Medicare Plus (HMO), HNE Medicare Premium (HMO), and HNE Medicare Secure (HMO) Employer Group Waiver Plans must use HNE network providers for all routine medical care. Members enrolled in our HNE Medicare Freedom (HMO-POS) Point of Service and HNE Medicare Secure Freedom (HMO-POS) Point of Service plans can choose to get routine medical care from network providers or use their Point of Service benefit to get care from non-network providers. HNE Medicare Freedom and HNE Medicare Secure Freedom members pay more when they use non-network providers for routine medical care. Some services require prior authorization. Our network providers know what we cover under your benefit plan. They also know what requires prior authorization and will request approval from HNE on your behalf. Members of the HNE Medicare Freedom (HMO-POS) and HNE Medicare Secure Freedom (HMO-POS) plans who choose to get these services out-of-network are responsible for getting prior authorization from HNE. Please tell your out-of-network provider that prior authorization is required. The provider may be willing to contact HNE Member Services for you to get prior authorization. Call Member Services to confirm prior authorization. For a complete list of services that require prior authorization, refer to the Summary of Benefits. Services authorized by HNE Medicare Advantage Employer Group Waiver Plan and other services contained in my HNE Medicare Advantage Employer Group Waiver Plan Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR THE HNE Medicare Advantage Employer Group Waiver Plan WILL PAY FOR THE SERVICES.**

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with HNE Medicare Advantage Employer Group Waiver Plans, he/she may be paid based on my enrollment in HNE Medicare Advantage Employer Group Waiver Plan.

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that HNE Medicare Advantage Employer Group Waiver Plan will release my information including my prescription drug event data to Medicare (if applicable), who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

Your Signature:	**Today's Date:**

If you are the authorized representative, you must sign above and provide the following information:

Name: _____

Address: _____

Phone Number: _____

Relationship to Enrollee _____

Below section to be completed by employer

Group Name: _____

Group/Div#: _____

Effective Date: _____

New enrollment reason:

❒ Annual open enrollment ❒ Retirement ❒ Moved into service area ❒ Other

Employer Signature _____ Date: _____

Office Use Only:

Name of staff member/agent/broker (if assisted in enrollment): _____

Plan ID #: _____

Effective Date of Coverage: _____

ICEP/IEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____

Glossary of Terms

CO-PAY: A specific amount of money you pay for services such as doctor visits and prescription drugs. The insurance company pays the remaining costs.

DEDUCTIBLE: A specific amount of money which must be paid within the health insurance plan year before the insurance company begins making payments on claims.

HMO (Health Maintenance Organization): A health plan that provides coverage for treatment by a network of doctors and hospitals within a specific geographic area. An HMO requires the selection of a PCP (Primary Care Physician).

PCP (Primary Care Physician): Includes physicians with specialties in internal medicine, family practice and pediatrics. For HMO members, you must select a PCP to coordinate your health care.

PPO (Preferred Provider Organization): A health insurance plan that offers coverage by network doctors and hospitals but also provides a lower level of benefits for treatment by out of network providers. A PPO does not require the selection of a PCP (Primary Care Physician).

NETWORKS: Groups of doctors and hospitals that contract with an insurance plan. If you are in a plan that offers network and non-network coverage, you will receive the maximum level of benefits when you are treated by a network provider. If you utilize the services of a non-network provider, you may be subject to additional costs. The incentive is to stay in network.

EAP (Employee Assistance Program): Free, confidential 24 hour a day, seven day a week services for you and your family that include help for depression, marital issues, family problems, alcohol and drug abuse and grief. The EAP also includes referrals for legal, financial, family mediation and elder care assistance.

COBRA (Consolidated Omnibus Budget Reconciliation Act): A federal law that allows you to continue your health insurance coverage for a limited period of time after group coverage ends as a result of certain employment or life event changes.

MEDICARE: A federal insurance program for retirees age 65 or older and certain disabled people. Medicare Part A covers inpatient hospital care, some nursing facility care and hospice care. Medicare Part B covers physician care, diagnostic tests such as lab work and x-rays and durable medical equipment such as a wheelchair. Medicare Part C is the combination of Part A & B. The main difference is that it is provided through private insurance companies approved by Medicare. They are often called Medicare Advantage plans. Medicare Part D is a federal prescription program.